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FAMILY PLANNING

PREPARING FOR THE

CENTURY

Principles for Family Planning Service Delivery in the Nineties

Family Planning Services Division
Office of Population
U.S. Agency for International Development
Washington, D.C. 20523

Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties

by

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ERRATA:

In Appendix C, the table listing FY 1991 Medium Priority countries that do not have bilateral programs should appear as follows:

FPSD FY 1991 Priority Countries

MEDIUM PRIORITY

FPSD Support to countries without bilateral population programs.

Country	Population (Millions)
Mozambique	15.7
Papua New Guinea	4
Paraguay	4.3
South Pacific	0.2
Thailand	55.7
Tunisia	8.1
Yemen	9.8
Zambia	8.1
8 Countries Total Population	105.9

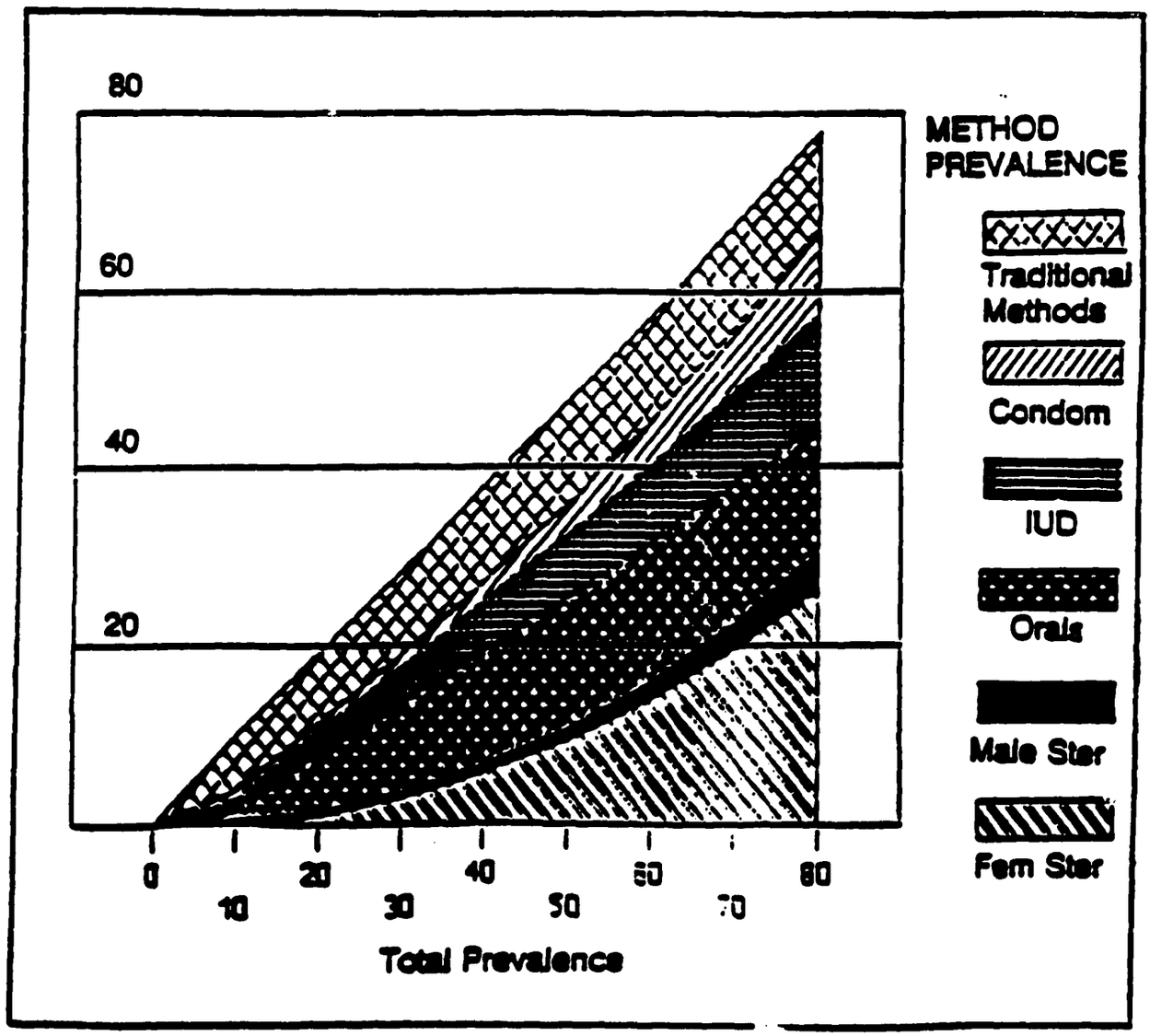
Please note that Figure 4, page 11, should have appeared as shown on the reverse of this errata sheet.

December 13, 1990

- C -

Figure 4

Estimated Change in Contribution of Contraceptive Method To Total Prevalence, As Prevalence Rises



Preface

In beginning a new endeavor, particularly one as ambitious as this paper, the crucial question one faces is - Why? Why engage in a process that is difficult, and may challenge the way we currently view the world and our role in it? The answer is simple and equally crucial: WE CANNOT AFFORD NOT TO. The future demand for family planning services will outstrip even our most optimistic estimates of future resources. As we enter into the 21st Century, the population community will face increasingly difficult investment decisions regarding the best use of our resources in order to have the greatest impact.

With this in mind, the Family Planning Services Division began conceptualizing and developing its strategy in January 1989, in order to delineate the issues related to the demand and supply of family planning services and to outline a strategic approach to address these issues. A first draft of the paper was presented and discussed during the Divisional session of the Cooperating Agencies meeting in April 1989. Since that time we have engaged in a collaborative process of review and discussion with our colleagues in the Office of Population; individual CAs and their field staff, USAID Mission staff, donors, and our host country counterparts; to share thoughts, seek input and collectively to develop a document useful to family planning professionals and the organizations in the field with whom we work.

At each stage of this process we gained new insight, exchanged ideas, and incorporated the many valuable concepts and comments generated by our colleagues. While this has been a long process, it has been thoughtful, constructive and fruitful. We believe that the document reflects the depth and level of effort that has gone into this endeavor, and presents innovative concepts for the allocation and management of family planning resources. The strategy also sets the agenda and presents the challenge to all of us for family planning service delivery in the 21st Century. While these challenges are great, we together have the tools to address them. At the same time, because of evolving knowledge and new approaches to family planning, we view the strategy as the beginning of a dynamic process.

It is the hope of the Services Division that the concepts outlined here will provide insight and guidance to the many people in the field implementing family planning programs. For our part, the framework developed for analyzing needs and establishing priorities, as well as the principles established for service delivery, will remain a cornerstone of the investment and management strategy of the Division for some time to come.

We would like to thank all of our colleagues mentioned above who participated in this process and contributed to the overall quality of the paper. We also wish to express our thanks to the leadership of the Office of Population and our fellow colleagues in the Office for their support of this endeavor.

Finally, I would like to thank and commend the people without whom this important document would not have been written - the talented staff of the Services Division whose input was invaluable; the staff at POPTECH who worked so diligently to produce this document; and my colleagues - John Stover, Janet Smith and especially Harriett Destler, all of whom advanced original thinking for the field of population and developed this document into becoming what I believe will be a landmark.

Dawn Liberi
Chief
Family Planning Services Division

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Glossary

CA	Cooperating Agency
CBD	Community-based distribution
CSM	Contraceptive social marketing
CYP	Couple year of protection
DHS	Demographic and Health Surveys
FPSD	Family Planning Services Division
GDP	Gross domestic product
IEC	Information, education, and communication
IUD	Intrauterine device
MIS	Management information system
NGO	Non-governmental organization
NORPLANT®	Five-year contraceptive implant
POPTECH	Population Technical Assistance Project
PVO	Private voluntary organization
QC	Quality control
S&T/POP	Bureau for Science and Technology/Office of Population (A.I.D.)
STD	Sexually transmitted disease
TA	Technical assistance
VSC	Voluntary surgical contraception

Executive Summary

A Changing Environment

Dramatic changes have occurred in the family planning environment in developing countries. These changes, coupled with those expected in the next two decades in family planning demand and technology, have led the Family Planning Services Division (FPSD) of A.I.D.'s Office of Population (S&T/POP) to reexamine its process for allocating and managing resources. This review, undertaken in conjunction with A.I.D.-assisted Cooperating Agencies (CA), underscores the need for a more strategic and analytic approach in the 1990s to family planning service delivery. Such an approach must reflect lessons learned about service delivery, a diverse and changing family planning environment, and new opportunities resulting from improvements in contraceptive technology and acceptance of family planning.

This paper* reflects the products of this A.I.D.-CA dialogue and proposes ways to improve planning and resource allocation. The paper is premised on A.I.D.'s overall objectives in population assistance. These are 1) to lower fertility so that rates of population growth are consistent with the growth of economic resources and productivity and 2) to enhance the freedom of individuals within the developing countries to choose voluntarily the number and spacing of their children. It focuses specifically on the goal of S&T/POP/FPSD -- to increase contraceptive prevalence through the development, expansion and improvement of family planning programs throughout the developing world. The recommendations are limited therefore to those related to increasing the availability of safe, effective services.

Very important changes have occurred in developing country populations and family planning programs over the past 25 years. These include dramatic rises in populations; the development of population policies and programs to slow the rate of increase; successful family planning programs which have lowered fertility and decreased family size; improvements in contraceptive technology; more efficient approaches to service delivery; and increased international donor support. Successes in family planning have resulted in a dramatic increase in demand for family planning services. Even with anticipated increases in donor and host country support, resources to meet the expected increased demand (from 192 million users in 1990 to 286 million in 2000) could fall short by as much as $1.4 billion a year by the year 2000. Meeting this challenge will require A.I.D. and the CAs to find better ways to coordinate, allocate, and manage population assistance resources.

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*_Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties_ has evolved over the past year as a result of meetings between S&T/POP/FPSD and CAs concerned with service delivery. The paper has benefitted considerably from the CAs' insights and those of other colleagues within A.I.D. and the larger population community who commented on an April 1989 draft. Comments on new directions in policy, IEC, training, and research were also received but are not included because they are beyond the scope of this paper.

A New Framework

To assist in the management of service delivery resources, a new framework for analyzing worldwide program needs and priorities is proposed. This framework, or typology, categorizes A.I.D. recipient countries in five levels depending on the level of ***modern method*** contraceptive prevalence. Since there is a strong correlation between modern method contraceptive prevalence and the national family planning policy and program environment, there are generally distinct patterns of family planning knowledge, supply and method mix at each level. For example, as prevalence rises, a greater proportion of family planning acceptors choose permanent or longer-lasting methods. Also, as programs mature, there is often a greater division of roles between the public and the private sector, with the for-profit sector providing more of the supply methods of contraception. Based on worldwide experience with family planning program development, it is possible to identify common needs and successful actions taken in other settings to meet these needs and strengthen programs at specific levels of development.

The Nineties Principles

Analysis of past experience, gains in family planning technology and expected increases in demand suggest six important principles for service delivery in the 1990s. These are that 1) service delivery must emphasize quality of care; 2) service delivery must expand to serve larger populations in more cost-effective ways; 3) service delivery must evolve to accommodate a diverse, younger population and improved method mix; 4) all sectors, i.e., government, private voluntary organization (PVO) and for-profit, must cooperate in family planning service delivery; 5) sustainable services must be developed; and 6) greater attention must be paid to comparative advantage, strategic position and managerial efficiency.

Three of these principles for the nineties relate to necessary changes in service delivery systems and the other three to resources for service delivery. Implicit in all principles is a triad of service delivery concerns -- ***quality, quantity, and cost*** -- that must influence all decisions on the design, support, and management of service delivery projects.

New Approaches to Resource Allocation

Drawing upon the typology and the nineties principles, FPSD and its CAs are revising the way resources are allocated and projects developed, approved and monitored. Criteria are being developed for country and subproject selection. Criteria for country selection include preference for sub-Sahara Africa, low prevalence countries, countries of demographic importance, countries without bilateral population assistance, private sector involvement, and anticipated return on investment. Criteria for subproject selection reflect both the broad general guidelines that underlie A.I.D.'s and FPSD's programming strategies and the six nineties principles. Greater emphasis is placed on the use of analytic and management tools to improve planning, monitoring and evaluation. Although considerable progress was made in the eighties in understanding service needs and priorities and approaches to improved design and implementation, the systems and methodologies to support such activities are still limited and in some cases inadequate. In the nineties, greater attention must be paid to the coordination of donor and CA inputs; better measures of impact of population assistance and programs; return on investment and cost effectiveness; and joint planning and analysis.

1. Background

Over the past 25 years, major changes have occurred in every aspect of developing country population and family planning programs. Populations have risen dramatically. Most countries have developed new policies and programs to slow the rate of increase. Family planning programs have produced changes in fertility behavior and more efficient service delivery models and have introduced better contraceptive technology. National governments and international donors have increased support for family planning programs. Family planning successes have led to substantial increases in demand, especially for long-lasting methods of contraception. Meeting the expected increases in demand will require a significant increase in resources and a multisector approach to service delivery.

Demographic Change

Since 1965 when A.I.D. first provided population assistance, there have been major demographic changes in developing countries. Death rates have fallen. The developing country population, excluding China, has grown from 2.3 billion to 3 billion in 1975 and again, to around 4 billion by the beginning of the 1990s. Over the past 20 years, the number of women of reproductive age has doubled. This doubling explains a central population paradox: more couples are using contraception; the average number of births per woman has declined sharply; and yet population continues to increase rapidly. Another demographic change has been a major population increase in urban areas, due both to an increase in population and to migration.

Population Program and Policy Change

Over the past 25 years, acceptance and use of family planning have increased markedly. Organized family planning programs have contributed importantly to these changes. Specifically,

- Numbers of contraceptive users in the developing world (excluding China) have increased from 15 million to 200 million;
- Prevalence for all methods has increased from 9 percent of married women of reproductive age to about 45 percent, primarily due to an increase in the use of modern methods;
- Largely as a result of family planning programs, total fertility -- the average number of births per woman -- has dropped from 6 to 4.2; and

- Dramatic shifts in fertility behavior have resulted from the major changes in government and donor policies in support of family planning.[1]

Governments have developed policies favoring lower rates of population growth and support for family planning. In 1959 India was the only developing country with a population policy. Now 63 countries, with over 90 percent of the total developing country population, have policies that support slower population growth, and 95 provide support for family planning.[2]

There remains considerable variation among and within countries with respect to access to modern contraceptive methods and the related contraceptive prevalence. In 1982 at least half the population in most Latin American countries had "ready and easy"[3] access to one or more contraceptive methods, while this was true in less than 50 percent of Asian and only 12 percent of African countries. Fertility decline in developing countries is closely associated with increased contraceptive prevalence. Changes have been greatest in East Asia and least in Africa (see Figures 1 and 2).

Changes in Family Planning Services and Methods

Service Delivery Changes

As prevalence has increased, programs have evolved and the family planning service delivery marketplace has become more complex, involving a combined effort by public, private voluntary, and commercial organizations.

The relative role of the different sectors varies considerably from country to country. In some countries, for example Brazil, the for-profit sector is a major provider of family planning commodities. The private voluntary sector is an important actor in other countries, such as Haiti. In Tunisia, the public sector program has been very successful, but it is becoming increasingly clear that the public sector cannot carry the load alone. Tunisia is starting to look at contraceptive social marketing (CSM) as a way of increasing private provision of services, much as Indonesia has done.

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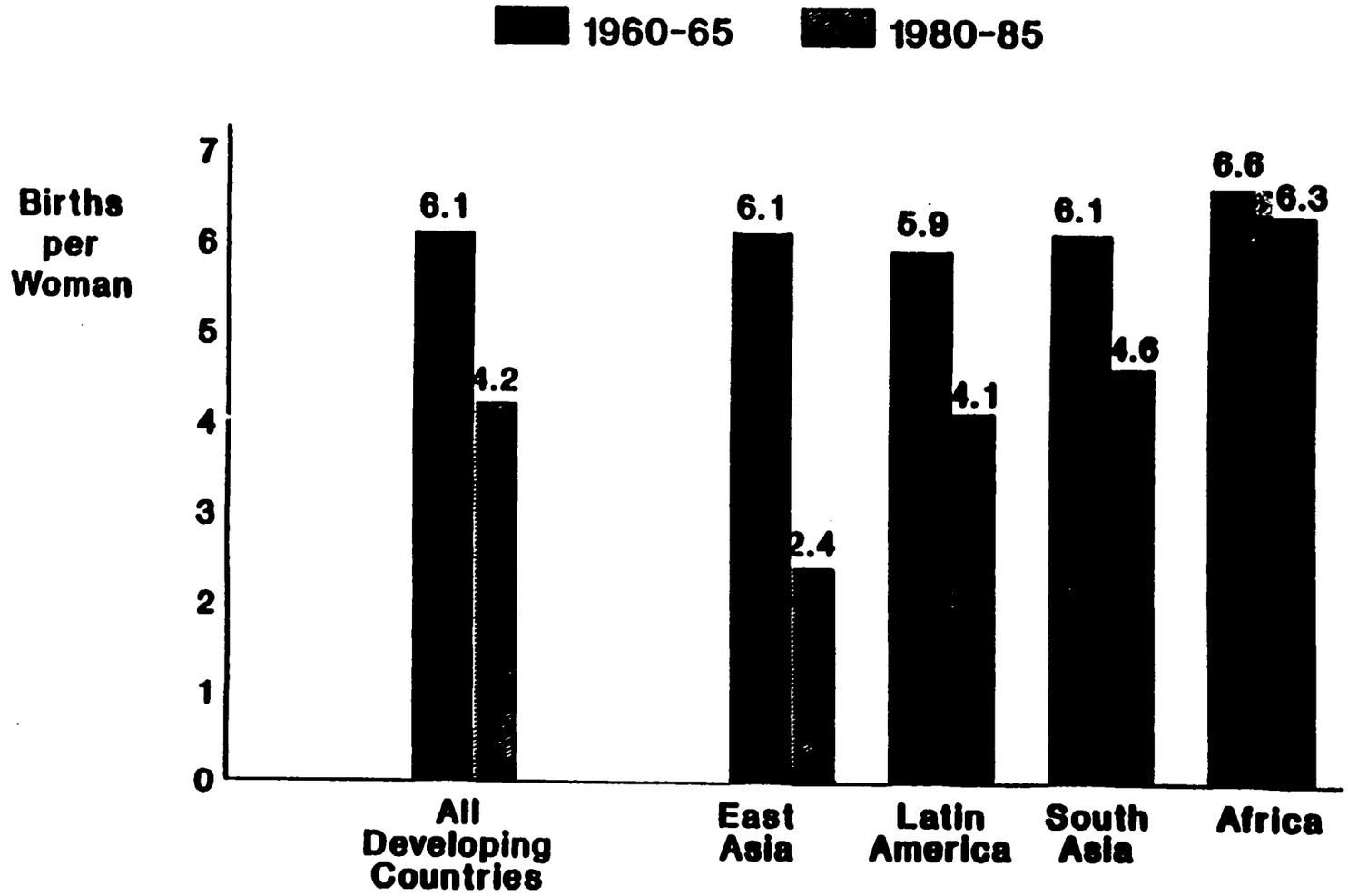
[1]Duff Gillespie, Harry Cross, John Crowley and Scott Radloff, "Financing the Delivery of Contraceptives: the Challenge of the Next Twenty Years." Paper presented to the National Academy of Sciences, Washington, D.C., October 7, 1988.

[2]Elizabeth Maguire, "The Evolution of A.I.D. and Other Donor Assistance in Population Policy." Paper presented before the UN/IUSSP Expert Group Meeting, United Nations, New York, June 27, 1988.

[3]"Ready and easy access" was defined as the recipient having to spend "no more than an average of two hours per month to obtain contraceptive supplies and services and that the cost of contraceptive supplies was not burdensome" i.e., "a one-month supply of contraceptives should cost less than 1% of a month's wages." p. 66, Department of International Economics and Social Affairs, Population Studies No. 110, *Levels and Trends of Contraceptive Use as Assessed in 1988*, United Nations, 1989.

Figure 1

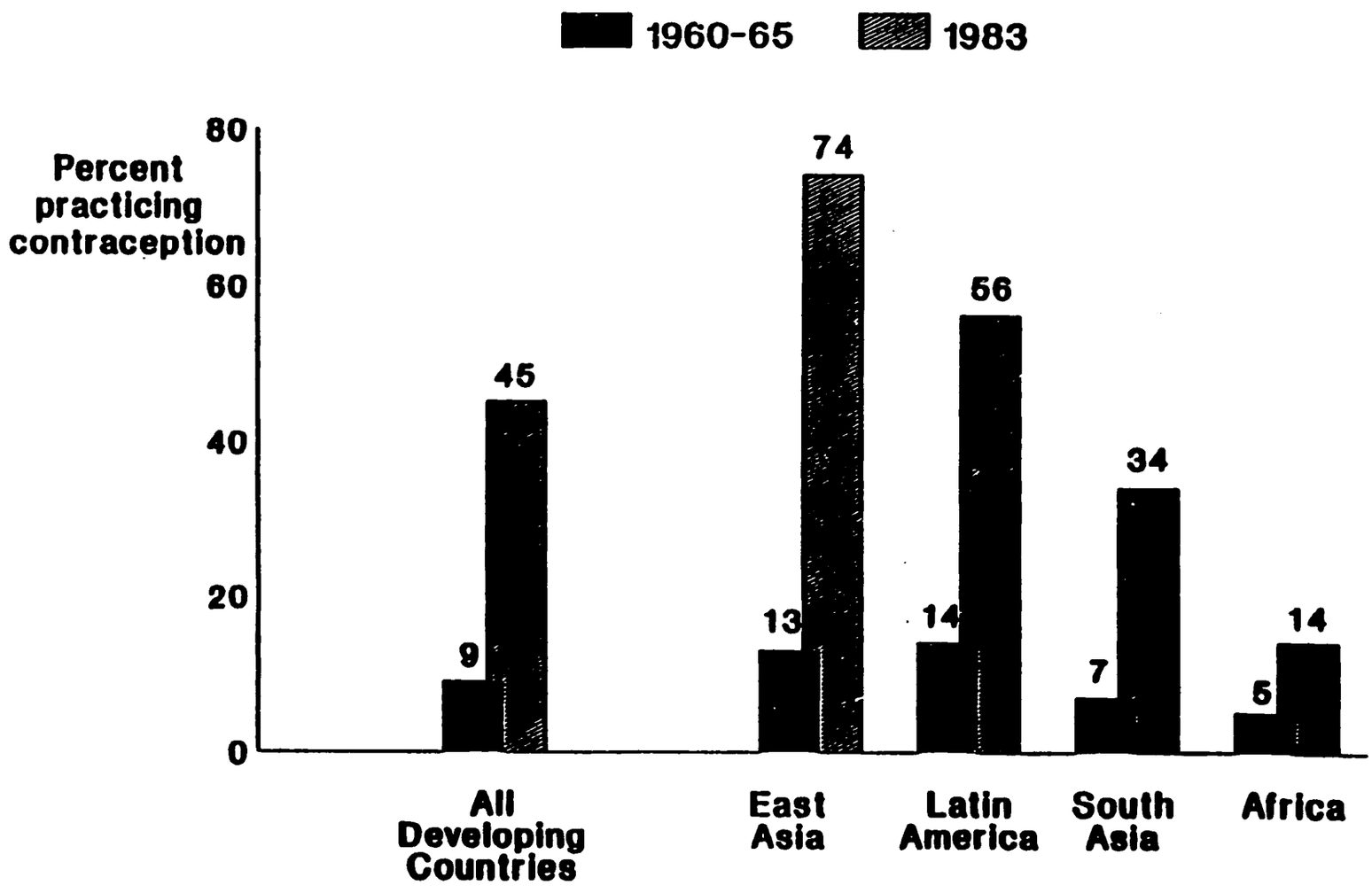
Fertility Trends in the Developing World, by Region



Source: United Nations, 1988. From John Bongaarts, Parker Mauldin, James Phillips, *The Demographic Impact of Family Planning Programs*, The Population Council, Paper Prepared for the Meeting on Population and Development, Development Assistance Committee of OECD, April 1990, Paris.

Figure 2

Trends in Contraceptive Prevalence, by Region



Source: United Nations, 1989. From John Bongaarts, Parker Mauldin, James Phillips, *The Demographic Impact of Family Planning Programs*, The Population Council, Paper Prepared for the Meeting on Population and Development, Development Assistance Committee of OECD, April 1990, Paris.

In Latin American countries, new collaborative service delivery systems are being developed that draw upon the joint resources of the public and private sectors. As more entities become involved in service delivery, coordination of efforts and agreement on their respective strengths and roles become very important.

Changes in Contraceptive Technology

Contraceptive technology has improved considerably. In 1965, for example, the condom was the most popular method; oral contraceptives had just been introduced, and female sterilization was a lengthy hospital procedure. Now, the three most common methods in developing countries are sterilization (used by 45 percent of those contracepting), the IUD (24 percent), and the pill (12 percent).[4]

Improvements in technology have contributed to the dramatic increase in the popularity of sterilizatio Female sterilization can now be done as a one-day, outpatient procedure, making it more feasible, safe and attractive to clients. The development of a no-scalpel male sterilization technique may make vasectomy more popular. The hormonal dosages in oral contraceptives are much lower and safer. A new, highly effective IUD, the Copper T380A, is available.

Four new contraceptive methods are now under review that may become the methods of choice in the 21st century.[5] Like the IUD and sterilization, these new methods are long-acting and require clinic settings, specially trained providers, counseling services and strong management systems to ensure informed choice and quality care.

Changes in Population Assistance

Although developing country governments provide the major portion of support for family planning programs, international assistance continues to be very important. In 1988 when total expenditures for family planning were estimated at $3.2 billion, developing country governments provided $2 billion or 62 percent; consumers, $550 million or 17 percent; and donors, $659 million or 20 percent.[6]

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[4]p.5, John Bongaarts, Parker Mauldin, James Phillips, *The Demographic Impact of Family Planning Programs*, The Population Council, Paper Prepared for the Meeting on Population and Development, Development Assistance Committee of OECD, April 1990, Paris.

[5]These are 1) NORPLANT®, 2) NET 90-Day Injectable, 3) a biodegradable implant which contains NET pellets, and 4) the Filshie clip for female tubal sterilization.

[6]Population Crisis Committee, *1990 Report on Progress towards Population Stabilization*, Briefing Report no. 23, Washington, D.C., 1990.

Total International Assistance

International population assistance from the mid-1950s through 1985 totaled about $5.6 billion. The large growth in assistance began in the mid-1970s with $1.8 billion having been added from 1975 to 1980 and $2.3 billion from 1981 to 1985 (Figure 3).

In 1988, international population assistance totaled about $660 million.[7] An estimated $534 million of this came from developed countries (with A.I.D. providing $245 million), $85 million from the multinational banks, and $40 million from private philanthropic groups.[8] The funds reach recipient government and non-government family planning programs directly through bilateral, or government-to-government, programs and indirectly through intermediate United Nations and private international organizations.

A.I.D. Population Assistance

The United States, through A.I.D., leads the donor community in providing population assistance. Over the past 25 years, A.I.D. funding for population assistance has totaled $3.9 billion. Since 1981, $2.9 billion has been provided. In FY 1989, A.I.D. obligated $255 million, more than half of the total bilateral population assistance.

In FY 1989, A.I.D. funded population and family planning activities in over 90 countries. Directed at lowering fertility and improving the health of individuals, A.I.D. population assistance has two objectives: 1) "to enhance the freedom of individuals in LDCs to choose voluntarily the number and spacing of their children, and 2) to encourage population growth consistent with the growth of economic resources and productivity."[9] Increasingly, assistance is being provided through bilateral agreements with host governments. In FY 1989, more than half of the population assistance was provided through agreements with 37 countries: 16 in Africa; 10 in Asia and the Near East; and 11 in Latin America and the Caribbean. Most of the remaining assistance was provided through A.I.D.'s central Office of Population (S&T/POP), which works on a worldwide basis to strengthen family planning programs.

The Family Planning Services Division (FPSD) manages about 40 percent of S&T/POP resources to increase contraceptive prevalence through the development, expansion and improvement of family planning programs worldwide. FPSD's portfolio has evolved to reflect the changing needs of developing countries. Important changes include:

- services directed toward specific high-risk groups;
- a shift of resources to low prevalence countries in Africa and the Near East from the high prevalence countries in Asia and Latin America;

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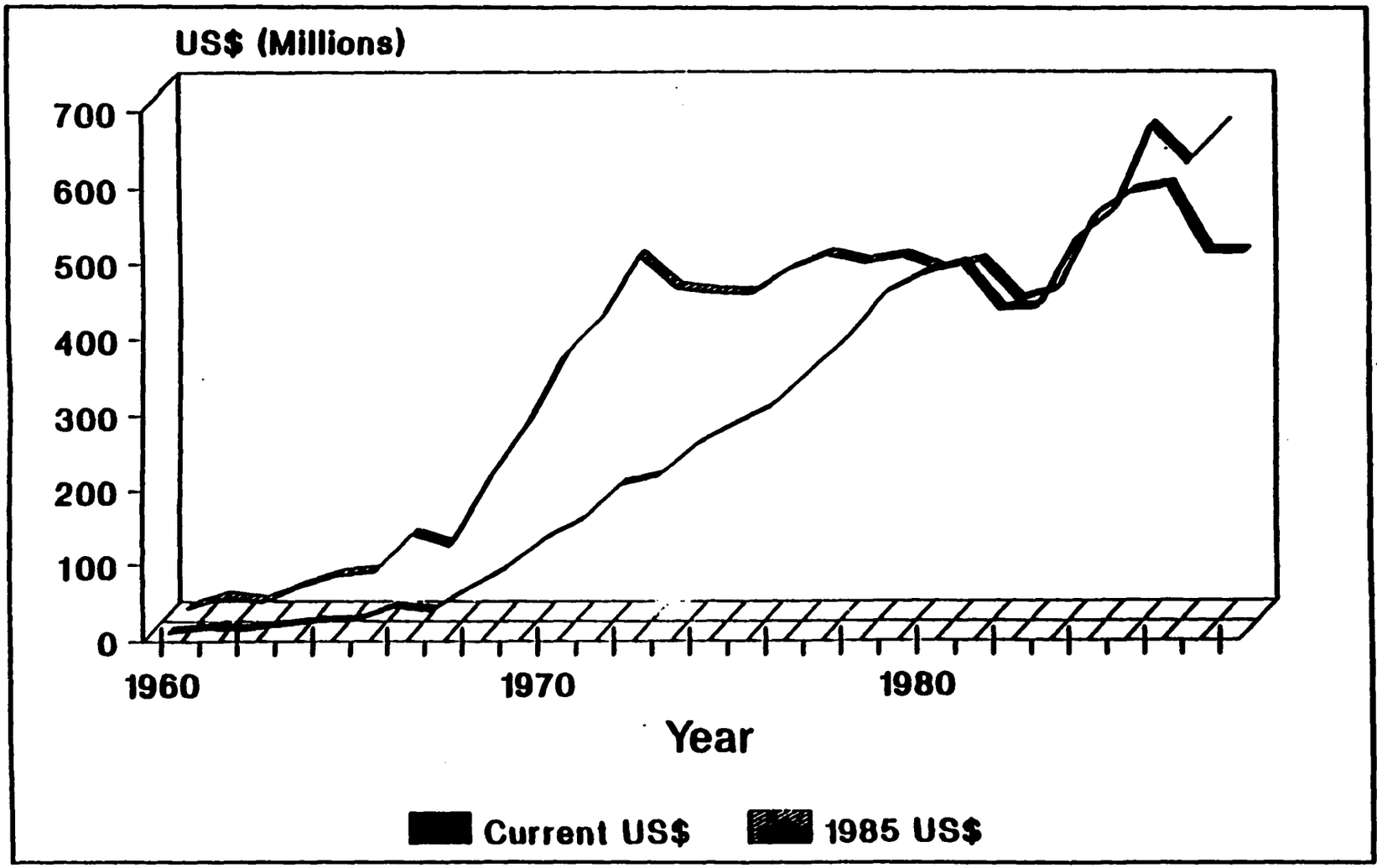
[7]Ibid.

[8]Ibid.

[9]p.4, A.I.D. Policy Paper, *Population Assistance*, United States Agency for International Development, Washington, D.C., September 1982.

Figure 3

Total Population Assistance
1960-1988, in Current and 1985 U.S. Dollars



Source: UNFPA, *Global Population Assistance Report*, September 1, 1989, p. 14.

- greater emphasis on the development of sustainable institutions;
- increased coordination with bilateral programs;
- cooperative efforts with the private for-profit sector; and
- the introduction of new contraceptive technology.

Changes in Demand and Resource Needs

Over the next two decades, the demand for family planning services -- and the attendant financial burden -- will rise dramatically. This will happen inevitably because the numbers of women of reproductive age in the developing world will increase substantially as a result of natural increase. Demand is also likely to increase because of improvements in socioeconomic conditions and changes in availability and knowledge of family planning services. Commensurate increases in resources and strategic use of these resources will be required to meet this demand.

Increase in Demand

The projected total number of family planning users in the developing countries exclusive of China in the years 2000 and 2010 is shown in Table 1. These estimates, aggregated by region, are based on country-specific projections of users corresponding to the United Nations high population scenario.[10] Overall, the number of users will more than double from 1985 to 2000, with another 43 percent increase between 2000 and 2010. This translates into an estimated increase of 5 percent per year from 1985 to 2000 and 3.5 percent per year from 2000 to 2010.

Table 1

Projected Number of Modern Method Family Planning Users by Region
(by years 1985, 2000, and 2010)
(Millions)

Region	1985	%	2000	%	2010	%
Africa	9	7	32	11	66	15
L. America/Carib.	29	22	48	17	64	15
Asia	92	71	206	72	307	70
Total	130		286		437	

[10]If world population growth rates were to decline more steeply to accord with the United Nations medium growth projections (as discussed in the Population Crisis paper on population stabilization, op. cit.), a contraceptive prevalence rate of 75 percent would be required. In this scenario, much larger numbers of users would need to be served.

Demand for eight different methods of family planning in developing countries exclusive of China has also been projected for the years 2000 and 2010 (Table 2). The projection is based on an average pattern of method mix/prevalence relationships that changes from less effective to more effective methods as prevalence rises (see Figure 4, page 11). Specifically, it shows that the use of traditional methods is widespread in countries with very low levels of prevalence, that there is an increase in oral contraceptive use as prevalence increases from 10 percent to 45 percent, and that use of female sterilization increases rapidly at levels above 45 percent.

Table 2

Projected Number of Family Planning Users by Method
(by years 1990, 2000 and 2010)
(Millions)*

Method	1990	%	2000	%	2010	%
Female sterilization	70	36	91	32	124	28
Male sterilization	10	5	15	5	20	5
Orals	34	18	57	20	96	22
Injectables/Implant	7	4	11	4	17	4
IUD	7	9	30	10	55	13
Condoms	17	8	22	8	33	8
Vaginals	1	1	2	1	5	1
Traditional	38	20	56	20	83	19
Total	184		286		437	

*Since data on users by method for many countries are inexact, these numbers should be taken for order of magnitude only.

Increase in Resource Requirements

The costs of meeting this increased demand will rise dramatically, even if costs drop from the present average of $18.10 per user to the projected level of $14.70 per user by the year 2010.[11] Applying the cost estimates per user to the number of users by method, an overall

[11]In this paper, costs are estimated based on decreasing marginal cost. The estimation method assumes that costs per user will decline as prevalence increases because of economies of scale, reduction of public sector requirements as an increasing proportion of users gets services from the private sector, and an increasing use of long-lasting, more cost-effective methods. Regression analysis indicates that there is a significant, inverse relationship between cost per user and contraceptive prevalence, meaning that as prevalence rises, costs go down. Source: John Stover, *Projections of Resources Required and Available for Population Programs*, The Futures Group, Washington, D.C., 1989; cost data derived from Rodolfo Bulatao, *Expenditures on Population Programs in Developing Regions*, The World Bank, 1985. This is a conservative estimate. Higher cost estimates result if the methodology is used as outlined in Gillespie, et al., *Financing the Delivery of Contraceptives*, where commodity costs for each method are combined with an average service delivery cost of $20.

projection can be made of the total donor/government resources that will be required by the years 2000 and 2010.

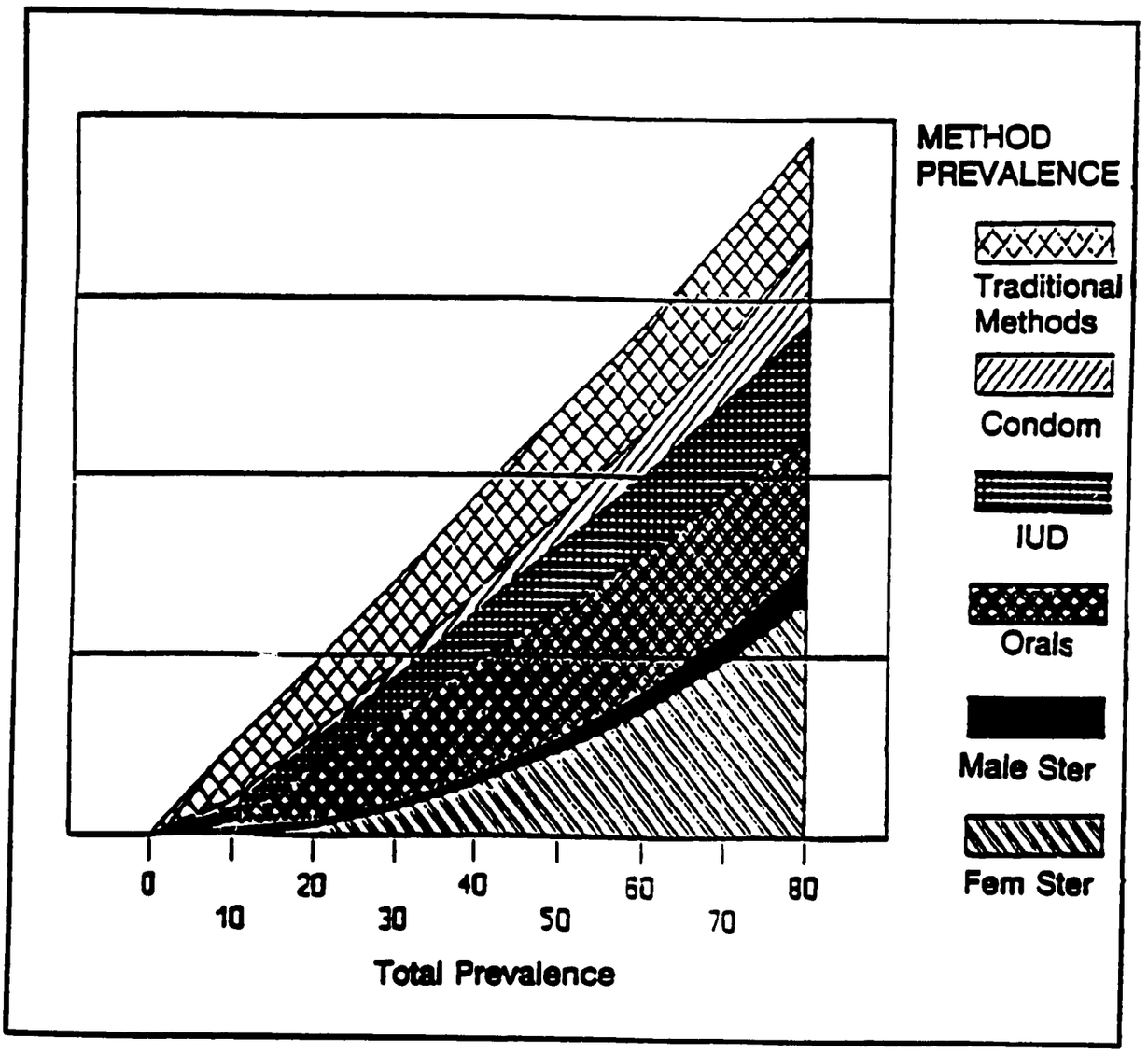
This methodology suggests that the projected total annual need for resources would rise from $2.3 billion in 1985 to $5 billion in the year 2000 to $7 billion in 2010. This would require an annual increase in resources of 5.3 percent per year from 1985 to 2000.

An increase of this magnitude in government/donor resources for population programs will not be achieved easily. If donors and local governments were to increase population budgets between 1985 and 2000 at the same rate as the projected gross domestic product (GDP) growth in the donor countries (3 percent per annum), this would increase resources only $1.2 billion (from $2.3 billion to $3.6 billion). There would be a shortfall of $1.4 billion as of the year 2000. Meeting the more ambitious goal of reducing the rate of the growth to that of the medium growth projections would require a total of $10.5 billion in the year 2000,[12] or almost double the $5 billion that will be needed to achieve the high growth projection.

[12]Population Crisis Committee, *1990 Report of Progress toward Population Stabilization.*

Figure 4

Estimated Change in Contribution of Contraceptive Method To Total Prevalence, As Prevalence Rises



2. Framework for Analyzing Assistance Needs

In the evolving family planning environment, donors and CAs need a way to assess worldwide needs and make macro decisions about resource allocations. In this chapter, a new framework is presented that supplements the traditional regional framework. This framework, or typology, groups A.I.D.-recipient countries into five levels depending on their level of modern contraceptive prevalence. Generally, there are distinct patterns of family planning knowledge, supply and method mix at each level. Likewise, there is usually a strong correlation between contraceptive prevalence and socioeconomic conditions. Because the family planning program profile is predictable for each level of prevalence, it is possible to identify important program initiatives to raise prevalence and meet growth goals. A.I.D. and the CAs have found this approach useful in developing multi-year strategic plans and in discussing the differing roles of assistance groups.

The Typology

Traditionally, population resource allocations and planning for country programs have been based on a regional perspective. Although regional characteristics continue to be important, the differences among countries within particular regions are now so great that the regional framework is inadequate. The need for an additional basis for macro analysis and planning has spurred the development of a new framework.

The framework -- or typology -- groups countries into five categories based on levels of ***modern method*** prevalence.[13] These levels are

- ***Emergent***, with 0 to 7 percent prevalence among married women of reproductive age;
- ***Launch***, with prevalence between 8 and 15 percent;
- ***Growth***, with prevalence between 16 and 34 percent;
- ***Consolidation***, with prevalence between 35 and 49 percent;
- ***Mature***, prevalence of 50 percent or higher.

Table 3 shows the program levels for A.I.D. recipient countries based on modern method prevalence circa 1988. Wherever possible, estimates of modern method prevalence from Demographic and Health Surveys (DHS) or other national surveys were used. Where such data were not available, modern prevalence was estimated through regression analysis based on the total fertility rate, GNP per capita and life expectancy.[14] This table underscores some important inter- and intra-

[13]Modern methods include sterilization, oral contraceptives, injectables, IUDs, condoms and vaginal methods. They do not include withdrawal, rhythm and traditional or folk methods. The typology was developed by John Stover of The Futures Group.

[14]John Stover,"Projections of Resources Required and Available for Population Programs," April 1989.

Table 3

Countries Receiving A.I.D. Population Assistance Categorized by Modern Method Prevalence (circa 1988)

Emergent 0-7%	Pop Millions	Launch 8-15%	Pop Millions	Growth 16-34%	Pop Millions	Consolidation 35-49%	Pop Millions	Mature ≥50%	Pop Millions
*Nigeria	110.1	*Pakistan	106.3	*India	815.4	*Indonesia	174.8	Brazil	144.4
Myanmar	40.0	*Nepal	18.0	*Bangladesh	108.9	*Egypt Arab Rep	50.2	Mexico	83.7
*Zaire	33.4	*Bolivia	6.9	*Philippines	59.9	Venezuela	18.8	*Thailand	54.5
*Tanzania	24.7	*Swaziland	0.7	Turkey	53.8	Sri Lanka	16.6	Colombia	31.7
Sudan	23.8			*Morocco	24.0	*Ecuador	10.1	Chile	12.8
*Uganda	16.2			Algeria	23.8	*Zimbabwe	9.3	Uruguay	3.1
Afghanistan	14.6			*Kenya	22.4	*Tunisia	7.8	*Jamaica	2.4
*Ghana	14.0			*Peru	20.7	*Dominican Rep	6.9	Panama	2.3
Cameroon	11.2			*Guatemala	8.7	*El Salvador	5.0	Barbados	0.3
Cote d'Ivoire	11.2			*Honduras	4.8	*Costa Rica	2.7		
Madagascar	10.9			Paraguay	4.0	Trinidad/Tobago	1.2		
Yemen Arab Rep	10.0			*Jordan	3.9				
*Burkino Faso	8.5			Lesotho	1.7				
Malawi	8.0			*Botswana	1.2				
*Mali	8.0			Mauritius	1.1				
Zambia	7.6			*Belize	0.2				
*Niger	7.3								
*Senegal	7.0								
*Rwanda	6.7								
*Haiti	6.3								
*Somalia	5.9								
Chad	5.4								
Guinea	5.4								
*Burundi	5.1								
Benin	4.4								
Sierra Leone	3.9								
*Papua New Guinea	3.7								
Togo	3.4								
Central African Rep	2.9								
Liberia	2.4								
Congo	2.1								
Mauritania	1.9								
Guinea-Bissau	1.0								
Total Population	427.0	Total Population	131.9	Total Population	1,154.7	Total Population	303.4	Total Population	335.2
Percent	18 %	Percent	6 %	Percent	49 %	Percent	13 %	Percent	14 %

Source: United Nations data.
*Bilateral Agreement Country 1990.

regional differences in family planning adoption. For example, 27 (or 81 percent) of the A.I.D.-assisted sub-Sahara African countries fall in the emergent category. Latin America and the Caribbean countries provide the reverse image with 19 (or 90 percent) at growth or higher levels. There are tremendous differences within regions, however; for example in the Asia region, Myanmar and Papua New Guinea are in the emergent category, Nepal is at the launch level, Bangladesh and the Philippines are at the growth level, Indonesia is at the consolidation level, and Thailand is at the mature level.

Countries grouped by modern method prevalence usually have similar socioeconomic and family planning program characteristics. This might be expected, given the important roles both socioeconomic development and organized family planning programs play in bringing about changes in reproductive behavior:[15] Countries that have low prevalence tend to have low socioeconomic status, and high prevalence countries tend to have high socioeconomic status. (Although the association between high acceptance and high socioeconomic status is more common, there are a number of exceptional cases in which family planning acceptance is high in low socioeconomic settings.[16]) The table in Appendix A lists the average values for socioeconomic characteristics for the five levels. The table shows that, for women in countries with low prevalence, maternal mortality rates are high and school attendance rates are low.

There is also, not surprisingly, an association between prevalence and family planning program development. In countries with higher prevalence, family planning services, supplies, and information are available through a range of providers and outlets. Furthermore, there tends to be a strong relationship between contraceptive prevalence and method mix, with a shift to more permanent methods (especially female sterilization) as prevalence rises. There are also important exceptions to this pattern in cases in which country-specific characteristics such as religious beliefs (in the case of Indonesia) or service supply factors result in a different method mix or different allocation of roles between government and the private sector.

The typology is expected to serve two different functions. At the country level, it should be useful in supplementing country-specific information as a basis for decision making about particular investments in a particular country. On a broader scale, it provides an analytic framework within which to review options and make macro decisions about relative allocations to blocks of countries.

Relating the Typology to Program Needs

Since different patterns of family planning knowledge, supply, and method mix are associated with the various levels of prevalence, the typology provides an opportunity to analyze in some depth the configuration of programs at each level. The discussion that follows gives such a snapshot of the expected type of family planning program for countries at each level of prevalence. This perspective should help donor governments and assistance agencies analyze global needs.

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[15] p. 4-5, Bongaarts et al., *The Demographic Impact of Family Planning Programs.*

[16] p. 4-5, ibid.

Level 1
Emergent

Modern Method Prevalence 0 - 7%

In countries in which the family planning program is at the emergent level, service delivery is limited, not very well known and may be provided by only a few dedicated individuals through government clinics or private associations. Usually service delivery begins in urban areas where there is family planning support and where services can be targeted at those easiest to reach and most likely to accept, e.g., women with large families or women immediately after delivery. An example is Burundi with total modern method prevalence of one percent, through injectables. An additional eight percent of the populace uses traditional methods. There are exceptions to this pattern; for example, in some countries like Mali, service delivery has been introduced first in rural areas, thanks to the efforts of charismatic leaders who have been important in gaining government acceptance and approval of new methods of service delivery.

The challenge at this level is to build support and credibility for family planning. Program activities aimed at increasing acceptance and prevalence include

Policy. **Exploring government positions on family planning and legal/procedural constraints to the delivery of family planning services, and developing support for family planning as a health intervention.**

Service Delivery. **Ensuring that clients receive adequate information and counseling to support appropriate selection and use of methods.** Early attention to assuring good care, a reliable supply of contraceptives, counseling, information and follow-up are essential in developing a cadre of satisfied, informed users who can help generate demand for family planning. Private non-profit programs may play a key role in demonstrating the feasibility and acceptability of family planning.

Information, Education and Communication (IEC). **Reaching key leaders or opinion makers with information and developing a family planning constituency.** Special studies, observational tours and special analyses can build support.

Institutional Base. **Developing additional human and institutional resources to expand service delivery.**

Financial Base. **Determining the costs of service delivery and potential financial base, with an eye toward leveraging resources and implementing cost recovery and/or cost sharing at the outset.**

Donor Support. **Broad and substantial assistance, perhaps multi-disciplinary. Coordination of assistance efforts** due to limitations of in-country program and administrative resources. A project like the Family Planning Services Expansion and Technical Support project (SEATS) can provide the substantial and multi-disciplinary approach needed for this level. Collaborative, PVO approaches of other CAs would also be helpful.

Level 2
Launch

Modern Method Prevalence 8 - 15%

The launch countries reflect two distinct patterns of population program evolution. The first pattern is demonstrated in countries like Haiti, which in the period 1988 to 1989 moved from the emergent to the launch level. Here recent investments and efforts by dedicated individuals have begun to have an effect and there now exists a broader institutional base, improved access to a variety of contraceptives, and increased knowledge of family planning alternatives. The second is found in countries like Pakistan, where, despite considerable effort by dedicated individuals and substantial donor support, family planning is stalled and prevalence has remained at a static level over time. The Pakistan program has been affected by changes in government.

The challenge here is to broaden the institutional base and client population and provide better information and services. Priority program activities to increase acceptance and prevalence include

Policy. **Government and popular support for family planning and the removal of barriers to service delivery.**

Service Delivery. **Attention directed to the availability of different methods.** Innovative ways of delivering services and expanding urban and clinic bases are needed. In conservative environments, providing acceptable access for women through religious or non-governmental organization (NGO) groups with community standing may be essential. Satisfied users can play an important role in generating demand. Special efforts may be required to meet the needs of couples with large families who have a potential need for sterilization services. Operations research should be conducted to test new service delivery approaches.

Improved family planning management capability as the number of service sites expands. This becomes essential as logistics, quality assurance, ongoing supervision and reporting become more complex and services like voluntary sterilization are added.

IEC. **Careful attention paid to consumer attitudes, knowledge, and prior experience with family planning.** Inaccurate information about contraceptive safety or efficacy and/or poor experience with family planning may be a particular problem in countries with established programs but low modern method prevalence. National information and communication strategies are needed to deal with the barriers to expanded service and acceptance.

Institutional Base. **An increasingly important role for the commercial sector.** Private institutions (commercial and nonprofit) must be encouraged to add family planning to the services they already provide their employees or members. Such private institutions may be able to provide acceptable accessible services in a conservative environment in which government support remains controversial. The government should work with community and women's groups and social service agencies to identify viable, acceptable institutions with an existing infrastructure and the potential to provide services to large number of clients.

Financial Base. **Development of mechanisms to promote programmatic and financial sustainability.**

Donor Support. **Provision of assistance from more specialized CAs, in particular, to meet training needs.**

Level 3
Growth

Modern Method Prevalence 16 - 34%

Countries at the growth level have successfully reached substantial segments of the better educated and more urban population. Demand for services is beginning to rise among less urban and less educated segments of the population while demand for longer-lasting and permanent methods is increasing among all segments of the population. Cost becomes a growing concern for the government, which is expected to continue to provide a substantial proportion of all services.

The challenge is to make family planning information and services more broadly available and thus to continue to increase prevalence. Priority program activities include

Service Delivery. **Expansion of services combined with assuring quality care, conserving resources, and improving provider effectiveness.** The institutional base for service delivery must be broadened and service delivery must become increasingly cost effective. Family planning needs to be integrated into other ongoing service programs. Clients need to be encouraged to switch to more effective methods. The results of operations research and pilot projects need to be applied to improve current service delivery and replicate or expand successful approaches. Low-cost delivery systems such as commercial social marketing and CBD need to be expanded to make temporary methods more available to low-income consumers and to meet increasing demand with adequate supply. An increased rural focus is needed in response to growth in demand. With increased interest in long-lasting and permanent methods of contraception, medical oversight, client information and counseling systems remain very important.

Institutional Base. **Greater emphasis on commercial support for family planning. More attention directed to market segmentation and the respective roles of government, the private voluntary and commercial sectors.**

Financial Base. **Initiation of studies to improve effectiveness and efficacy.** Investment capital from projects with a commercial emphasis may prove to be a new source of funding.

Donor Support. **Broad technical assistance, directed at all program components.**

Level 4
Consolidation

Modern Method Prevalence 35 - 49%

Countries with programs at the consolidation level face multiple challenges. Among the urban, educated groups, contraceptive prevalence remains high and demand is strong for effective methods like IUDs and sterilization. Poor and rural groups are also beginning to demand services. Program clientele have become more heterogeneous, and younger. The public sector is likely to be the chief provider of clinical methods like IUDs and sterilization, but the private sector should be starting to assume increased responsibility for the delivery of temporary methods like oral contraceptives and condoms.

The challenge at this level is to increase segmentation of the market to ensure that public and private resources are used most effectively. Program activities that should have priority include

Service Delivery. **Developing services that are responsive to a diverse and changing population and increasing access for the poor and uneducated clients.** In particular, this means supporting users who switch methods as their status changes from spacers to limiters. Multi-method promotion, consistent supply, and service quality all need to be maintained.

IEC. **Development of information systems that are responsive to a more diverse and heterogenous clientele.** This will involve use of mass media approaches.

Institutional Base. **Transfer of clients from the government to the private sector and development of collaborative approaches among public and private agencies.** Transferring of clients will involve moving acceptors from reliance on public service providers to such private sector services as those provided by employers, private health providers and the commercial market.

Financial Base. **Increased efforts to achieve self-sustainability.** Service delivery costs should be reduced through better management and program efficiency. Local support for services should increase.

Donor Support. **Identification of multiple sources for contraceptives. Leveraging of donor and private resources through currency conversion and corporate donations.**

Level 5
Mature

Modern Method Prevalence ≥50%

Countries are considered to have mature programs when modern method prevalence is above 50 percent. The most popular methods are sterilization, oral contraceptives and IUDs. Thailand ranks as a mature country with 66 percent modern method prevalence (22 percent female sterilization, 20 percent pill, 9 percent injectables, 7 percent IUDs, 6 percent male sterilization and 1 percent condoms). Traditional methods are only 2 percent. At this level, programs may face declining donor and in some cases government resources although substantial client populations still require subsidized services.

The major challenge facing countries with mature programs is to build upon the considerable success they have achieved to date. Priority program activities include

Service Delivery. **Broadening support base to maintain and increase existing high level of services. Encouraging clients to choose more effective methods wherever appropriate. Improving the quality of information and service to increase continuation rates for temporary methods.**

Institutional Base. **Broadening community support for public and non-profit programs and accelerating the transfer of clients from the public to the commercial sector. Limiting subsidized services to the most needy. Consideration given to the local production of contraceptive supplies.** In Asia the public sector is the largest source of family planning services although the private sector makes an important contribution. In Latin America, the private sector is the primary system.

Financial Base. **Program-level efforts to achieve the maximum level of cost recovery and sustainability possible within the limits of the country setting.**

Donor Support. **Attention to means to increase technical and financial sustainability.** This could include, for example, the ability to monitor and project contraceptive needs and finance contraceptive commodities through local resources.

Implications for Program Planning

The typology can be used with a model like TARGET, which calculates the prevalence level required to meet a fertility goal, to get some sense of the magnitude of program change required to meet a specific goal.

For example, if each of the A.I.D.-assisted countries listed in Table 3 set as its national goal achieving a rate of population growth that ***did not exceed the United Nations' high growth rates***, 22 of the 33 countries listed as emergent would need to move to the launch level and 10 countries -- Burundi, Cameroon, Ghana, Haiti, Nigeria, Papua New Guinea, Rwanda, Sudan and Yemen -- would have to reach the growth stage by the year 2000 (see Table 4). For some countries these are astounding changes which seem highly unlikely given the current level of program and institutional development. In many cases, this would mean doubling or tripling modern method prevalence this decade in extremely difficult settings. Similarly, countries like Egypt, Indonesia, Sri Lanka and Zimbabwe would have to achieve modern method prevalence of 50 percent or above by the year 2000.

Table 5 shows the even greater changes in contraceptive prevalence and concomitant program profiles that would have to be achieved by A.I.D. recipient countries if they are ***not*** to exceed United Nations high growth projects by 2010. This, too, would require an enormous program transformation, infusion of donor resources and expansion of facilities and personnel. Meeting this goal would require, for example, large countries like India and Pakistan to more than double their modern method prevalence.

Far greater increases in contraceptive prevalence would be needed if the United Nations medium growth projections are to be achieved and the world's population stabilized at between 9 to 10 billion. This would require an average worldwide prevalence of 75 percent by the year 2000 and $10.5 billion in annual support, in comparison to the current donor investment of approximately $659 million in 1988.

Table 4

Modern Method Prevalence Required in A.I.D.-Assisted Countries to Prevent Population Increase beyond UN High Growth Projection (2000)

Emergent 0-7%	Pop Millions	Launch 8-15%	Pop Millions	Growth 16-34%	Pop Millions	Consolidation 35-49%	Pop Millions	Mature ≥50%	Pop Millions
Afghanistan	24.2	Myanmar[E]	51.1	*Pakistan[L]	162.5	*India[G]	1,042.5	*Indonesia[C]	208.3
*Somalia	5.9	*Zaire[E]	49.3	*Nigeria[E]	159.1	Turkey[G]	66.6	Brazil	179.5
		*Tanzania[E]	39.6	Bangladesh	150.6	*Peru[G]	30.0	Mexico	107.2
		*Uganda[E]	26.3	*Philippines	77.4	*Nepal[L]	24.1	*Egypt[C]	66.7
		Cote d'Ivoire[E]	18.5	*Kenya	37.6	*Ecuador	13.9	*Thailand	63.7
		Madagascar[E]	16.6	Sudan[E]	33.6	*Guatemala[G]	12.2	Colombia	40.0
		*Mali[E]	12.7	*Nepal[L]	24.0	*Jordan[G]	6.3	Algeria[G]	33.2
		Zambia[E]	12.2	*Ghana[E]	20.4	Paraguay[G]	5.5	*Morocco[G]	31.4
		*Burkina Faso[E]	12.0	Cameroon[E]	14.8	Mauritius[G]	1.2	Venezuela[C]	24.7
		Malawi[E]	11.7	Yemen Arab Rep[E]	11.1			Sri Lanka[C]	19.4
		*Niger[E]	9.7	*Rwanda[E]	10.1			Chile	15.3
		*Senegal[E]	9.7	*Bolivia[L]	9.7			*Zimbabwe[C]	13.1
		Guinea[E]	8.9	*Haiti[E]	7.8			*Tunisia[C]	9.8
		Chad[E]	7.4	*Burundi[E]	7.2			*Dominican Rep[C]	8.6
		Benin[E]	6.6	*Papua New Guinea[E]	5.1			*Honduras[G]	6.8
		Sierra Leone[E]	5.4	Lesotho	2.3			*El Salvador[C]	6.7
		Togo[E]	4.7	*Botswana	1.8			*Costa Rica[C]	3.7
		Cent Afr Rep[E]	3.8	Guinea-Bissau[E]	1.2			Uruguay	3.4
		Liberia[E]	3.5					*Jamaica	2.9
		Mauritania[E]	2.7					Panama	2.9
		Congo[E]	2.6					Trinidad/Tobago[C]	1.5
Total Population	36.4	Total Population	315.0	Total Population	736.3	Total Population	1,202.3	Total Population	848.8
Percent	1.%	Percent	10 %	Percent	24 %	Percent	38 %	Percent	27 %

Source: United Nations data.
*Bilateral Agreement Country 1990.
[E]was at Emergent Level in 1988.
[L]was at Launch Level in 1988.
[G]was at Growth Level in 1988.
[C]was at Consolidation Level in 1988.
(Note: Swaziland and Barbados, which appear on Table 3, are omitted here due to lack of UN projection data.)

Table 5

Modern Method Prevalence Required in A.I.D.-Assisted Countries to Prevent Population Increase beyond UN High Growth Projection (2010)

Emergent 0-7%		Launch 8-15%		Growth 16-34%		Consolidation 35-49%		Mature ≥50%	
	Pop Millions		Pop Millions		Pop Millions		Pop Millions		Pop Millions
		Somalia[E]	13.2	*Nigeria[E]	216.2	*Pakistan[L]	205.4	*India[G]	1,225.3
				*Zaire[E]	67.4	*Bangladesh[G]	188.2	*Indonesia[C]	232.0
				Myanmar[E]	60.6	*Philippines[G]	92.0	Brazil	207.5
				Sudan[E]	56.3	*Kenya[G]	53.5	Mexico	125.1
				*Tanzania[E]	56.3	*Peru[G]	33.5	*Egypt[C]	78.5
				*Uganda[E]	44.0	*Guatemala[G]	15.8	Turkey[G]	76.6
				Afghanistan[E]	36.9	*Rwanda[E]	13.6	*Thailand	71.6
				*Ghana	32.8	Mauritius[G]	1.4	Algeria[G]	47.0
				Cote d'Ivoire[E]	27.0			Colombia	43.8
				Madagascar[E]	26.5			*Morocco[G]	37.0
				Cameroon[E]	19.3			Venezuela	30.0
				Zambia[E]	17.1			*Nepal[L]	28.9
				*Mali[E]	17.0			Sri Lanka[C]	21.5
				*Burkina Faso[E]	16.0			*Ecuador[C]	17.4
				Malawi[E]	16.0			Chile	17.1
				Yemen Arab Rep[E]	15.5			*Zimbabwe[C]	17.0
				*Niger[E]	13.3			*Tunisia[C]	11.3
				*Bolivia[L]	12.8			*Dominican Rep[C]	9.9
				*Senegal[E]	12.4			*Jordan[G]	8.9
				Guinea[E]	11.5			*Honduras[G]	8.7
				*Burundi[E]	9.6			*El Salvador[C]	8.5
				Chad[E]	9.5			Paraguay[G]	6.9
				*Haiti[E]	9.3			*Costa Rica[C]	4.4
				Benin[E]	9.0			Uruguay	3.6
				Sierra Leone[E]	7.0			*Jamaica	3.3
				*Papua New Guinea[E]	6.5			Panama	3.3
				Togo[E]	6.4			Trinidad/Tobago[C]	1.6
				Cent Afr Reg[E]	4.9				
				Liberia[E]	4.9				
				Mauritania[E]	3.5				
				Congo[E]	3.5				
				Lesotho	3.1				
				*Botswana	2.4				
				Guinea-Bissau[E]	1.6				
Total Population	0.0	Total Population	13.2	Total Population	822.4	Total Population	603.4	Total Population	2,346.7
Percent	0 %	Percent	0 %	Percent	22 %	Percent	16 %	Percent	62 %

Source: United Nations data.
*Bilateral Agreement Country 1990.
[E]was Emergent Level in 1988.
[L]was Launch Level in 1988.
[G]was Growth Level in 1988.
[C]was Consolidation Level in 1988.
(Note: Swaziland and Barbados, which appear in Table 3, were omitted here due to lack of UN projection data.)

3. Principles for Service Delivery in the Nineties

With the dramatic increase in demand for family planning services and in prevalence, donors, CAs and national governments are being required to adapt their population assistance strategies to respond to a variety of new service delivery challenges. At the same time, their response is made more difficult by resource constraints. This paper proposes ***six service delivery principles for the nineties****, designed to meet these challenges. They are based on lessons learned during the past two decades and governed by a triad of critical factors:* ***quality, quantity, and cost****. The first three principles focus on the demand side of service delivery -- the importance of service quality in generating demand and supporting continued use; the sheer magnitude of expected increases in numbers of users; and the accompanying changes in the type of users and in methods they will require. The second three principles look at the supply side -- the need for all sectors to cooperate in providing services; the need to address sustainability; and the need to determine the comparative advantage of the different resources and to manage them efficiently. These principles are applied to the country typology to illustrate how decisions on important service delivery components will vary based on the country population program level.*

Lessons Learned

The experience of the past two decades has suggested key lessons in family planning service delivery that should be applied to future service design. The most important of these are summarized below.

Family Planning Works

Family planning, alone or in conjunction with socioeconomic development, contributes to changes in reproductive behavior and fertility reduction. A recent study concluded "that in the absence of family planning programs, fertility in the Third World would have been 5.4 births rather than the actual 4.2 for 1980-85."[17] The greatest declines in fertility have occurred in countries in which both development and family planning program efforts are high.[18] Strong family planning efforts, however, can also be significantly associated with fertility decline independent of the social setting as demonstrated in the Matlab region of Bangladesh. Conversely, in countries in which there has been economic growth but little family planning effort, fertility has declined little, less than one birth per woman on average.

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[17]Bongaarts et al., *The Demographic Impact of Family Planning Programs.*

[18]"The effects of development and family planning programs are...complex...The reason is that an 'interaction' effect exists between these two determinants of contraceptive practice and fertility...As a consequence, the fertility reduction that can be achieved with a given program effort in a particular country depends on the level of development in that country. . . [and] investments in socioeconomic development and family planning program have much more than simply additive effects on fertility." p.8, ibid.

Quality of Service is Paramount

Quality of care and the provision of accessible, safe, appropriate services that meet client needs are critical factors in the initial acceptance and generation of demand for family planning and in the subsequent expansion and success of the program. Recruiting a smaller number of family planning acceptors and providing good care for them has more impact on fertility reduction than recruiting a large number of acceptors whose needs cannot be met by the program.[19]

Making Services Available Promotes Public Acceptance

The broad availability of services and supplies is important not only for the adoption of family planning by individual users but, more generally, for public support. Successful programs make family planning services, supplies and information available through a range of providers and outlets. Familiarity and positive experience with family planning ***both*** decreases sensitivity and reduces fears in the community.

Providing Clients with a Choice Increases Prevalence and Program Success

The availability of multiple methods and the associated counseling and information services to support informed choice are important factors in raising the level of contraceptive prevalence. By designing programs to respond to the different information and contraceptive needs of a diverse clientele, program managers facilitate the initial adoption of an appropriate contraceptive method and enhance the likelihood of couple continuation. Choice may, however, reduce method-specific continuation by making switching easier.[20]

Delivery Systems Must Be Flexible and Client-Based

Responsiveness to client needs is an important element of program quality. Method mix and service delivery must evolve to support changes in client preferences. As programs become better established and prevalence rises, an increasing proportion of clients will choose more permanent long-acting methods. Ensuring client-based service delivery will require systems for monitoring client services and satisfaction and the institutional flexibility to adapt to changes in client preference for methods.

Cost Counts

Demand for family planning services is rising faster than public and private resources. It is no longer possible to support all service delivery approaches or programs. Service delivery costs have become an increasingly important factor in decisions about program support. In the eighties, considerable attention was paid to identifying and lowering service delivery costs. Important ways identified to lower cost per user or cost per couple year of protection (CYP) include direct cost recovery (fees for services, and supplies and/or community, or employer donations); leveraging of resources

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[19]p.13, Anrudh K. Jain, "Fertility Reduction and the Quality of Family Planning Services," *Studies in Family Planning*, Volume 20, No. 1, Jan./Feb. 1989.

[20]p.13, ibid.

(matching requirements, collaborative service delivery arrangements that draw upon other institutional or community resources, debt conversion, etc.) and program efficiencies (economies of scale, use of less costly service delivery approaches such as social marketing and CBD and more efficient delivery of more effective methods).

Principles for the Nineties

On the basis of these lessons learned, FPSD has identified six key principles for service delivery in the nineties. Implicit within these principles are a triad of critical factors: ***quality, quantity and cost.*** These should be influential factors in all decisions on the design, support and management of service delivery projects. Family planning service investment decisions, in other words, should strive to offer safe, acceptable services to the greatest number of clients possible, in the most cost-effective manner feasible.

1. SERVICE DELIVERY SYSTEMS MUST EMPHASIZE QUALITY OF CARE

Quality is a critical factor in the service delivery triad of quality, quantity and cost. Service delivery systems that do not offer a choice of safe, acceptable family planning services are neither acceptable nor cost effective. Improvements in program quality increase contraceptive prevalence and move programs forward. Conversely, poor service delivery can effectively "stall" a program by discrediting family planning or creating a negative view of important contraceptive methods. It is important that quality be maintained as services expand, new methods are introduced, and client numbers increase. If quality is good, new acceptors will be attracted, users will continue with family planning, and contraceptive prevalence will rise. Quality of care is an important human concern affecting the lives of individuals and their families. It is an important management concern which will ultimately determine the sustainability of a program, since a program's ability to attract resources is directly related to how its services are valued.

2. SERVICE DELIVERY MUST EXPAND TO SERVE LARGER POPULATIONS IN MORE COST-EFFECTIVE WAYS

With the current population structure of developing countries, service delivery programs will have to reach many more individuals in the nineties just to maintain current contraceptive prevalence rates. Reaching enough clients to limit growth merely to the levels set in the United Nations **high growth** projections will require an increase in the number of family planning users from 192 million users in 1990 to 286 million users in 2000 and then to 437 million users in 2010. This program change will require a massive expansion of the service delivery system and of family planning resources. Since public resources are not expected to rise as fast as service demand, programs will need to become more cost effective and innovative in their use of private sector resources and a clear determination will have to be made of the appropriate roles for public and private providers. Greater attention will also have to be paid to the impact of population assistance as measured by the effectiveness of the methods provided, increases in contraceptive prevalence and couple years of protection, and the costs of achieving such outcomes.

3. SERVICE DELIVERY SYSTEMS MUST EVOLVE TO MEET THE NEEDS OF A MORE DIVERSE AND YOUNGER POPULATION AND CHANGES IN METHOD MIX

Current analysis suggests that in the nineties contraceptive prevalence will rise and that the population seeking family planning services will be younger and more urban than in the eighties. The increase in prevalence will be accompanied by changes in clientele and method mix which will affect service delivery.

First, as prevalence rises, there will be an increase in both the number of clients and the diversity of clients. To respond to needs of a larger, more diverse population, programs will need market research, programmatic and institutional analysis, and an increase in attention paid to both the contraceptive and the informational needs of different segments of the population. Also important will be innovative approaches in service delivery and the communication of family planning information. These will, in turn, require changes in commodities, clinic facilities and supporting information and counseling systems.

Second, rises in contraceptive prevalence will be accompanied by increased demand for effective, modern methods. To meet this demand, service delivery systems will need the capability to provide these methods. Sterilization, IUDs, and implants like NORPLANT® require clinic delivery sites, counseling support systems and specially trained personnel. The delivery of clinical methods can be facilitated by new management systems to strengthen supervision and ensure quality control. Delivery of clinical methods is also enhanced when institutions are flexible and have the technical resources to adapt to changes in client preference and methods. Systems ensuring appropriate client-based service delivery for a changing population with changing family planning needs may need to be expanded to test approaches and monitor client services and satisfaction.

4. ALL SECTORS -- GOVERNMENT, THE PRIVATE VOLUNTARY AND THE FOR-PROFIT PRIVATE SECTOR -- MUST COOPERATE TO SUPPORT FAMILY PLANNING SERVICE DELIVERY

Meeting the needs of a larger, more diverse population requires multiple approaches and resources and the combined efforts of government, the private voluntary, and the for-profit sectors. As prevalence rises and service delivery expands, a greater proportion of the service delivery costs will need to be met with local private resources. Innovative ways of involving the private voluntary and the private for-profit sectors (including the informal sector) in family planning service delivery will need to be developed and tested. Government or PVO programs will continue to serve those with no other access to services. Increasing numbers of other clients must pay for services, however, if national coverage is to be achieved with limited public resources. Collaborative, intersectoral efforts will be needed to draw upon the special strengths of each of the sectors. A.I.D. and the CAs must accept the resulting higher program risk of testing the new interventions anticipated.

5. ATTENTION MUST BE DIRECTED TO DEVELOPING THE INSTITUTIONAL BASE AND RESOURCES TO SUSTAIN SERVICES

With increased demand for family planning service resources, greater attention will need to be paid to the costs of services, in-country institutional resources, ways to increase and augment donor resources (e.g., through debt conversion, tax benefits, and other financial mechanisms), alternative sources of support, and prospects for eventual sustainability. As with other program factors, the emphasis in sustainability changes as programs progress. Financial considerations cannot be the only factors that determine which programs receive support since there are great variations among programs and countries in service costs, local resources, and support for family planning. For countries at the initial stage of program introduction, donor assistance may need to be directed at demonstrating the acceptability of services, promoting involvement of key figures and facilitating identification of institutional resources for future in-country support. As initial acceptance is achieved and viable institutions identified, financial factors assume greater importance. It is important to examine the cost of doing business, the willingness of governments and other local groups to invest in family planning, the prospects for increased local support and the eventual sustainability of delivery systems. This requires information on service delivery costs, expectations for continued donor assistance, sources of local support, and program models that can be viable over time. Wherever feasible, governments should be encouraged to account for family planning in their national budgets, even if the programs are currently donor funded.

6. GREATER ATTENTION MUST BE PAID TO COMPARATIVE ADVANTAGE, STRATEGIC POSITION, AND MANAGERIAL EFFICIENCY

Donors and CAs will have to determine where and how they can be most effective given their human, financial, and technical resources; and they will need to develop strategies that reflect these strengths. All agencies need not work in all countries at all times. Project planners should also examine how projects mesh with country and institutional goals, in particular whether projects serve to strengthen existing institutions and whether project goals are set in the context of country development goals. Finally, assistance must be better managed, coordinated, and streamlined for the best use of limited resources.

Applying FPSD's Principles to the Typology

Thus far, the discussion has been general: It has proposed a new typology to describe service delivery programs at various levels of development and identified general principles to guide the expansion of services in the nineties. The remainder of this chapter discusses how FPSD and its CAs can apply the principles to the typology and develop a tool for program planning and review.

Combining the principles and the typology into a single matrix provides a powerful analytic tool for identifying issues, examining options and checking assumptions. Such a matrix is provided in Table 6. (Appendix B takes the process one step further and shows how key program components such as management, training and policy might vary by program level.) This examination

of program components is important because as programs evolve, clientele increases, method mix changes and programs become multisectoral, program operations will need to change in tandem.

The matrix provides a general model of how the emphasis on key program issues changes as programs grow and develop. The matrix does not represent the historical development of all countries nor can it be used like a cookbook to program future operations. It is not a substitute for specific, in-country data.

Notwithstanding these caveats, the basic thesis is that an analytic approach based on the classification of national family planning programs into broad categories or classes by program levels can assist in program review at the macro level. It will always be possible to challenge the inclusion of a particular country in a particular level or the evolution of a specific element. Nonetheless, the thesis remains that there are unmistakable differences between the needs of an emergent country like Myanmar and those of a mature country like Thailand. Indeed, Thailand may more closely resemble Colombia than it does its geographic neighbor, Myanmar. Both Thailand and Colombia are mature countries with similar method mixes and levels of prevalence. Although they have followed somewhat different paths and placed quite a different emphasis on public and private provision, they have arrived at the same point with similar program profiles and priorities. In short, despite exceptions and divergences from the general pattern, there remains an essential core of characteristics that describe programs at distinct levels.

The matrix in Table 6 is a first attempt to apply the principles to the typology. The results reflect discussions with the CAs at the 1989 CA meeting and the strategies and workplans of service CAs. This first effort will need to be further refined with the help of colleagues and counterparts.

The following discussion provides an amplification of the information provided in Table 6: specifically, a look at what happens during five stages of program development if the six principles are applied at each level.

Quality

At the emergent level, small programs are often managed by dedicated individuals who are able to provide good quality services to highly motivated, early adopters.

As programs expand beyond the initial group of motivated acceptors and become more complex, there is a need to regularize and institutionalize quality assurance. Further attention is paid to quality in a range of settings: delivery of basic supply methods, clinical method provision, and multi-method promotion. Attention is also directed to quality as it pertains to the range of providers: rural promoters and private sector providers as well as medical and paramedical staffs. Tunisia exemplifies the increased emphasis on quality in the growth stage; at that point in its family planning program evolution, two major technical assistance efforts were Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) and the Association for Voluntary Surgical Contraception (AVSC).

The focus on quality service delivery has an effect on data collection. A range of data is collected to permit monitoring and evaluation and the data are made available to the providers to ensure ongoing improvements in services. At the emergent level, quality monitoring may be *ad hoc*, but as services

Table 6

FPSD's Principles as Applied to Typology

Programming Principles	Emergent	Launch	Growth	Consolidation	Mature
	0-7%	8-15%	16-34%	35-49%	≥50%
Quality of Care	Small programs able to meet quality needs of early adopters.	As clientele increases, new programs open and new types of programs launched (urban and pilot rural CBD); quality needs become more systematic.	Quality services needed in general in basic supply methods, clinical method provision, multi-method promotion and for quality services by rural promoters and private sector providers.		
Client Populations	Urban early acceptors. High parity women.	Urban and peri-urban early and educated acceptors. Rural pilot projects.	Urban and peri-urban early and educated acceptors, initiate broad rural programs.	All urban populations, emphasis on rural acceptors.	All populations, focus on hard-to-reach groups, e.g. adolescents, men.
Method Mix by Stage	Transition from traditional methods to supply methods. Maintain effective breastfeeding.		Encourage method switch from less to more effective.	Climate of acceptability and availability lets choice prevail.	Variety of methods, each adds to prevalence.
Types of Methods	Pills, condoms. Female VSC. Encourage effective breastfeeding (all stages).	Pills, IUDs, Norplant® (when approved), injectables, condoms. Female VSC.	Pills, IUDs, Norplant®, injectables, condoms. Female VSC increasing rapidly.	Pills, IUDs, Norplant®, injectables, condoms, female VSC.	Female VSC is most popular method. Pills, condoms, IUDs Norplant®, injectables, vasectomy should be promoted.
Sector Involvement	Limited system of fixed government and private facilities serving urban early adopters. Private voluntary organizations play a key demonstration role.	Government/private association. System expanding but additional private facilities needed. CBD in cities, rural pilot projects.	Private sector becoming major supplier of pills. CSM directed at meeting specific consumer needs. Demand for VSC growing and facilities to provide clinical methods coming on line (increase in government participation). Rural facilities and mobile teams needed.	Private sector strong in delivery of temporary methods. Public sector strengthening delivery of clinical methods since demand for more effective methods increasing.	Public sector system well developed to provide clinical methods. Private sector potential is large and realized in LAC, increasing in Asia.

FPSD's Principles as Applied to Typology

Programming Principles	Emergent	Launch	Growth	Consolidation	Mature
	0-7%	8-15%	16-34%	35-49%	≥50%
Sustainability	Cost recovery systems needed for services to urban early adopters for clinic and temporary methods.	Marketing to A&B (upper income) consumers/cost recovery for services to urban groups which can afford to pay.	Social marketing to C&D (lower income) consumers.		Cost recovery/social marketing systems sustained. Market segmentation of consumers/pricing structure well delineated.
			Cost participation for low income consumers of services for voluntarism, compliance and appreciation of services		
Comparative Advantage	Public sector: Integrating FP in MOH clinics. Private sector: linking FP program to modern and indigenous social groups, e.g. worker-based programs, market women, etc. Commercial sector: supply methods to pharmacists/ physicians.		Emphasize sector with biggest payoff for increased prevalence.	Equalize competency levels among sectors/agencies and reduce overlap.	All sectors involved and roles well understood.

expand and the number of sites and providers increase, there is a need to formalize and institutionalize collection of data on service delivery quality. As clinical methods like voluntary surgical contraception (VSC) become more prominent, monitoring of quality becomes more important, both in terms of technology and client protection. As programs mature, responsibility for monitoring also devolves more and more to the programs themselves.

Client Populations

As programs evolve, there is a change in the populations for whom services are targeted. In nascent programs, the earliest users of family planning are often women with high parity, urban residents, and members of elite groups. There are, of course, exceptions in cases in which pilot rural CBD programs were introduced early in the program development process. As family planning becomes more broadly accepted and most of the urban population has access to services, the focus moves gradually to rural areas. In Tunisia, for example, a concerted emphasis on rural expansion helped that country reach the consolidation stage. At the mature stage, programs change their focus again, this time to hard-to-reach groups like adolescents. As programs expand, decision makers begin to make use of increasingly complex information on service delivery. Data needs for monitoring and evaluation are no longer limited to the very simple measure of new acceptors but include data on such indicators as CYPs, continuing users, contraceptive prevalence, and, in the mature stage, total fertility rates.

Method Mix

As programs evolve, changes occur both in the methods that are available and in client preferences for various methods. These changes have important implications for service delivery.

Initially, the most prevalent modern methods are supply methods like pills and condoms, although some demand exists for IUDs and VSC from couples who have already reached their desired family size. Subsequently, additional long-acting methods such as IUDs, injectables and NORPLANT® become more important.

Haiti provides a good example of a country which between 1988 and 1989 moved from the emergent to the launch stage. According to a 1987 survey, pills were the most common method, followed by VSC. Injectables, NORPLANT®, IUDs, and condoms to prevent sexually transmitted diseases (STD) were also part of the method mix.

Over time, although the mix of available methods may remain constant, client preferences will change. In particular, couples who have reached desired family size switch to more effective methods and often choose female VSC. At the mature stage, female VSC is the most prevalent method.

Sector Involvement

As a result of the changing method mix and the increased use and acceptance of family planning, the roles of the various sectors change over the life of any given program. In the earliest stages, the highest demand in the general population is for supply methods, although for high parity women, there is a demand for IUDs and VSC. Services are provided in a limited system of fixed facilities supported by the public and private sectors. Haiti provides a good example: Its infrastructure includes a rudimentary network of public sector fixed facilities and PVO providers which together are initiating family planning services.

As demand rises, each sector takes a growing responsibility for services for which it has a comparative advantage. In many countries, the private sector becomes increasingly the major supplier of pills. For example, although its program started as a mixed public-private program guided by effective public sector leadership, Jamaica now has a successful social marketing program that highlights the prominence of private sector delivery of supply methods. At the later stages, the potential for private sector participation becomes more significant, as demonstrated by the strong private programs in countries such as Colombia and Mexico. In Tunisia and Indonesia, where strong public sector programs have brought contraceptive prevalence to the mature stage, emphasis is now being placed on increased private sector involvement. Indonesia now has a well-developed social marketing program. Tunisia is instituting cost recovery in clinics and beginning a social marketing program. Pharmacies have been the largest supplier of oral contraceptive during the growth and later stages.

Despite the trend toward private sector providers, the public sector network of clinical facilities often continues to be the main resource for meeting increased demand for sterilizations. Thailand and Tunisia are good examples of countries that have reached the mature or consolidation stages and that have strong public sector programs providing clinical methods. The comparative advantage of the public sector in this area is illustrated particularly well by the heavy use of IUDs and the large, successful VSC program in Tunisia.

Sustainability

The approach to generating local resources and developing sustainable institutions varies from country to country. In some cases, modest cost recovery mechanisms such as fees have been initiated at the early stages to contribute to service expansion and establish a value for family planning. A number of the poorer countries -- which also tend to be those with the lowest contraceptive prevalence levels -- have such weak revenue bases and limited public resources that people must pay for services. Haiti, in fact, is trying to increase private sector service provision to compensate for the limitations on public sector resources. PVO multi-method services, condom and pill social marketing, and efforts to develop services in the work place are all under way in that country. Some PVO services, such as injectables, build in user payments for services right from the beginning.

An early emphasis on cost recovery has not been the pattern for other countries. Some decision makers in Thailand have been concerned that use of fee for service would act as a brake on expansion in this country where high acceptance rates are viewed as critical to development. In Jamaica, the strategy has been to introduce services on a no-fee basis and subsequently to introduce cost recovery to a population that has had some experience with family planning.

As programs evolve, some have found it useful to increase market segmentation, with subsidized services directed at those least able to pay. Pricing strategies are developed to respond to differences in client abilities to pay. This requires increasingly sophisticated information on program costs and client profiles as well as the ability to test the impact of alternative pricing strategies.

Comparative Advantage

As donors and nations seek to meet growing demand for family planning with limited resources, greater attention is paid to comparative advantage or to where and how each donor and CA can be most effective by building upon its institutional strength, mandate and resources.

A.I.D.'s comparative advantages are in technical assistance expertise, headquarters and field staff, bilateral relationships, flexibility of its applied population research program and private sector initiatives. This means concentrating on program initiatives that draw on these strengths. The World Bank's capital resources and strong position in macro economics give it a comparative advantage in addressing policy and resource concerns and assisting countries to develop the infrastructure necessary to support family planning. UNFPA's strengths flow from its long association with the developing countries that are member nations, its access to multinational resources and its broad approach to development. This enables UNFPA to provide assistance across a spectrum of program areas.

Similarly, each of the CAs that works with FPSD has organizational strengths, particular approaches, and affiliations with other organizations and sectors, and these serve to provide each CA with certain advantages in some settings but not in others. It is up to each CA to define clearly its comparative advantage and where they can make the maximum contribution.

4. Operationalizing the Nineties Principles

To meet the family planning service delivery challenges of the nineties, optimal use must be made worldwide of family planning resources. For A.I.D., the major bilateral supporter of family planning services in developing countries, this imperative has particular relevance. Within A.I.D., the Family Planning Services Division (FPSD) of the Office of Population and the CAs with which it works are changing the process by which resource allocations are made and projects developed, approved and monitored. Drawing on the typology and nineties principles, FPSD is revising its regional goals, country priorities and subproject criteria to support more selective investment. Similarly, S&T/POP's CAs are drawing upon the typology and principles to develop multi-year strategies and annual workplans. Progress at the planning stage is good, but additional efforts are needed to improve coordination of efforts and evaluation. Evaluation is expected to be strengthened with improved databases and special analytic tools that are being developed, but issues of information and methodology remain to be resolved.

Introduction

As previously indicated, A.I.D. provides more population assistance than any other bilateral donor. In FY 1989, A.I.D. contributed $252.2 million, more than half of the total bilateral population assistance offered worldwide. Given the influence implied by this level of involvement, A.I.D. has a responsibility to be sensitive to developing country needs and to capitalize on improved approaches to allocation and use of family planning resources. This responsibility falls particularly heavily on S&T/POP's Family Planning Services Division (FPSD), and on the CAs with which it works, since together, they are charged with carrying out the central S&T/POP mission of delivery of family planning services to increase contraceptive prevalence and lower fertility. Because of the magnitude of assistance, the investment decisions made by these CAs have an appreciable effect on the level of services available in the developing countries.

In the section that follows, the typology and nineties principles are used to refine the criteria in use for the allocation and use of central A.I.D. resources for family planning service delivery. As the criteria themselves have become clearer, it has also become evident that refinements are needed in the systems through which they are applied. These will need to be addressed and resolved in the nineties to prepare for the 21st century.

S&T/POP and FPSD Goals and Objectives

Within A.I.D., a little more than half of the population assistance is programmed directly with host country governments through bilateral or government-to-government agreements. The remainder of the population assistance is programmed through the Office of Population, which plays an important leadership role in improving family planning service delivery, contraceptive technology, information and training, commodity supply systems, and policy.

Although bilateral resources are often used to buy into a particular S&T/POP project to acquire commodities and services for a specific country, S&T/POP's resources are generally

reserved for those activities which have an important impact on more than one country or region; lead to improved systems or processes and/or assist developing countries without bilateral population assistance. Often, S&T/POP will play an important interim role in helping a country launch a program which will subsequently receive bilateral population assistance, or in helping a country which has achieved A.I.D. graduate status in other sectors to develop the institutions to sustain population programs. Other key factors in determining which countries receive S&T/POP support are contraceptive prevalence and demographic importance (country size and rates of growth) and the expected outcome of such assistance. For management and cost reasons, S&T/POP prefers to support larger, multi-year projects wherever feasible.

Increasingly, S&T/POP is giving priority to assistance to sub-Saharan Africa. This is a reversal of the historical trend, in which Africa has received less population assistance than other regions. In part because of the low level of population assistance, Africa still includes a large number of countries at the early stages of population program development with limited family planning institutional bases, low contraceptive prevalence levels, and high infant and maternal mortality rates. Adverse socioeconomic trends and the declining ability of national governments to support services make the current need for donor assistance to public sector programs particularly acute. For family planning services to expand, better ways are also needed of drawing upon and using local private resources.

Within S&T/POP, the largest division in terms of CA staff and program budget is FPSD. FPSD's primary goal is to raise contraceptive prevalence by providing increased access to safe, acceptable family planning services through support of the development, expansion and improvement of family planning programs throughout the developing world. In line with the division of labor between S&T/POP and the regional bureaus, FPSD focuses its resources on those countries without significant bilateral population programs. Buy-ins to FPSD projects from bilateral populations assistance programs are encouraged to provide access to these specialized technical resources.

FPSD Portfolio Mix

FPSD currently works with seven CAs. These include four U.S. private voluntary organizations: the Association for Voluntary Surgical Contraception (AVSC), the Center for Development and Population Activities (CEDPA), International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR), and the Pathfinder Fund. In addition, the CAs include three U.S. companies: DUAL & Associates, Inc. (technical assistance in the design and evaluation of family planning through the Population Technical Assistance [POPTECH] project), The Futures Group (the Contraceptive Social Marketing [CSM II] project), and John Snow Inc. (family planning with the private sector through the Enterprise project and the expansion of family planning programs in low prevalence countries through the SEATS project).

The CAs and the subprojects they sponsor reflect a combination of factors: historical patterns of support for family planning service delivery; lessons learned about service delivery needs; and more recent emphases on improving method mix, increasing private sector involvement and support to low prevalence countries. All projects are judged on their contribution to service delivery. They face an increasing challenge to demonstrate how their approach and use of resources responds to the family planning services triad of concerns: quality, quantity and cost.

FPSD Regional and Country Priorities

Focusing in particular on those countries without bilateral population assistance, FPSD has set regional investment goals for its central funds of 35 percent in Africa, 25 percent in Asia and the Near East, and 35 percent in Latin America and the Caribbean. Five percent is allotted to worldwide activities. In 1989, the actual investment was 25 percent in Africa, 22 percent Asia and the Near East, and 43 percent Latin America and the Caribbean. This suggests that FPSD CAs must make greater efforts to direct resources to African and other low prevalence countries.

There is a need to go beyond regional goals and be more selective about which countries and which sectors within countries receive support. With respect to country choices, FPSD has worked closely with the regional bureaus to develop a list of priorities upon which to base a ranking of priority countries. The criteria, which reflect A.I.D. goals, S&T/POP and regional bureau guidance, the principles for the nineties, and the country typology, are as follows:

1. ***Region.*** Preference to sub-Sahara Africa.

2. ***Level of Prevalence.*** Preference to low prevalence countries at the emergent or launch stage of program development.

3. ***Demographic Importance.*** Preference to countries with large populations and high population growth rates.

4. ***Bilateral Support.*** Preference to countries with no bilateral population support.

5. ***Sector.*** Preference to activities that promote private sector involvement and support for family planning.

In applying these criteria, first preference, in general, is given to demographically significant or low prevalence countries. Investment decisions also reflect S&T/POP's special responsibility for countries without bilateral population assistance, and country-specific factors such as the policy and program environment and the expected increases in contraceptive prevalence resulting from the assistance. Preference is given to countries or situations within countries where investments in family planning build upon gains in population policy or program development to reach new or larger populations; serve high-need populations; leverage resources; and/or promote more effective methods, new technologies or innovative approaches to cost recovery and sustainability. The return on investments in family planning (i.e., improvement in quality of service, numbers reached, or cost per unit of service) will vary according to program level.

For example, the division of labor between S&T/POP and the Latin America and Caribbean region means that S&T/POP has responsibility for assisting in three relatively high prevalence Latin American countries -- Brazil, Colombia and Mexico -- because they are demographically significant and do not receive bilateral population assistance. For similar reasons, very few FPSD resources are targeted to demographically significant Asian countries such as Indonesia and Bangladesh because these have large bilateral population programs. India represents a somewhat different case in which limited FPSD support reflects difficulties in reaching agreement on joint initiatives and other operational constraints. On the other hand, Guinea, with a much smaller

population, is accorded priority because of its low prevalence high growth rate and its limited family planning infrastructure.

The investment strategies are different for countries at different stages of development. In the three high prevalence Latin American countries (Brazil, Colombia and Mexico), FPSD support is targeted at activities -- cost recovery, market segmentation of consumers and private sector involvement -- that increase local support for family planning and lead toward increased self-sustainability and declining reliance on donors. For Haiti, a high priority Latin American country that has a program profile much more like that of low prevalence countries in Africa than of its high prevalence neighbors, support is geared to increasing availability of services and prevalence.

Not surprisingly, the cost of providing family planning services in low prevalence countries is higher than in countries with more developed infrastructures, and the expected changes in terms of prevalence, new acceptors, or CYP provided are lower.

Population assistance like other forms of development assistance involves the collaborative efforts of A.I.D., other donors, U.S. public and private organizations and, of course, host country governments and organizations. The involvement of so many autonomous and sometimes changing groups, organizations and governments affects both the opportunities for and the constraints to effective population assistance and programming. In addition, changes in fertility and the successful use of family planning are affected by the individual decisions of millions of developing country citizens; by medical, social and institutional expertise and systems; and by evolving and still-imperfect technologies in family planning. It is in this complex milieu of real world constraints that population assistance and other investments need to be made and examined.

Each year FPSD develops a list of country priorities for central support and buy-ins in consultation with the regional bureaus. This list ranks countries as high or medium priority (see Appendix C for the 1991 listing). The annual ranking acknowledges the successes of earlier program efforts. Gains in contraceptive prevalence and increases in the number of countries with bilateral resources have reduced the need for CA involvement with S&T/POP funds in several countries. Increasingly, FPSD resources are now concentrated in a more limited number of countries.

Collaborative Planning Process

A.I.D., other donors and the CAs are working jointly to develop and support family planning programs in the developing world. Although A.I.D. and the CAs share common goals and purposes, organizational mandates and strengths may dictate somewhat different programming priorities, preferences and procedures. To facilitate agreement on program directions and implementation, FPSD and the CAs have adopted a collaborative planning process. This process has a number of steps -- development of a multi-year strategy statement and annual workplan, agreement on subprojects based on pre-existing selection criteria, joint review, approval of all CA subprojects in a country at one time rather than subproject by subproject, and monitoring and evaluation. Each of these steps represents an opportunity for FPSD and the CAs to exchange ideas and information and reach agreement.

This collaborative planning process is still evolving. Some elements, such as the multi-year strategy, are in place and working well, while others, such as subproject selection criteria and certain evaluation measures, need further discussion and refinement. There remain important methodological and operational challenges that need to be addressed.

Multi-Year Strategy

In their multi-year strategies, the CAs present their mission and vision for both their organization and the project. These analyses set forth the CA's general strategic objectives, present the rationale for the selection of activities, and explain the CA's comparative advantage for the task. The multi-year strategy thus addresses the operating principles underlying the CA's work -- its goals and objectives, regional plans, plans for institutionalization, capacity building, sustainability, etc.

The multi-year strategy, developed to guide a period of several years' work, relates to the ***purpose*** level of the project. The strategy lays out plans for achievement of outcomes (such as development of service systems) or impact (such as increase in contraceptive prevalence or reduction in fertility). By contrast, the annual workplan may be more concerned with the output level of the project. The multi-year strategy also addresses the three aspects of the triad -- quality, quantity, and cost -- as they pertain to the CA's program. As an element of quality, method mix is likewise part of the multi-year strategy, the aim being to achieve changes over time toward use of more effective methods.

The multi-year strategy, which is updated annually or as needed, initiates the dialogue between FPSD and the CA. It becomes a basic reference for conduct of the activity. Subsequent plans such as those in the annual workplan and those for subprojects are expected to link closely with the strategy.

The basic elements of the multi-year strategy are

- Mission;
- Goals, strategies, and objectives;
- Outcomes or impacts that the strategies aim to achieve;
- Comparative advantage of the CA to achieve the objectives;
- Background, including description of history and rationale for activity, demographic trends, other donor assistance, etc.;
- Priorities, including sector, country and regional priorities; and
- Sustainability.

Annual Workplan

The annual workplan makes operational the multi-year strategy. If the multi-year strategy lays out a continuum of progress toward an ultimate goal, the annual workplan identifies in one-year increments what needs to be done to move forward on that continuum. This has implications for planning, requiring sufficient detail to demonstrate how annual objectives will be met, and for measurement, quantifying with meaningful indicators the objectives and accomplishments of concern in the project year.

The annual workplan, thus, is a detailed, operational plan from which a project may be managed. The workplan reviews the previous year's activities and proposes activities for the current year. It also specifies how the activities contribute to the overall goals of the program and are coherent with the strategy. Furthermore, the workplan looks at how progress is defined, measured and reported and specifies evaluation plans for the activity. Plans for evaluation should be linked to the multi-year strategy, to ensure that the data collected on program operations are useful measures of the purpose level indicators.

The elements of the workplan include the following:

- Overview of project: background, strategy, and goals;
- Review of previous year's accomplishments;
- Objectives for current year;
- Annual program description with sectors, countries and regions identified;
- Proposed new initiatives and relationship to strategy;
- Resources, including financial, infrastructure, and human resources;
- Staffing, training and skill mix;
- Evaluation indicators and plans; and
- Implementation issues.

Subproject Selection Criteria

The next step in the collaborative planning process is for FPSD and the CAs to reach agreement on subprojects to be supported. Table 7 includes a list of criteria developed by FPSD and built into programming in planning for 1990 activities. These criteria respond to general A.I.D. programming requirements, FPSD's mission, and the six principles for service delivery in the nineties.

It is understood that these criteria cannot be applied mechanically or uniformly across subprojects. There are inherent tensions between criteria, and application will involve judgment, practical considerations, and weighing of priorities. For example, a strict financial sustainability criterion may not permit services to be delivered to poor consumers. Likewise, strict financial sustainability may not be suitable for emergent programs, in which it might inhibit the spread of services. Similarly, in terms of return on investment, new programs will be slower to produce results than older programs.

In short, program design is an art, in which balance, judgment and selectivity contribute to success. Both CA subprojects and CA portfolios must reflect such judgments, judiciously made, in the context of choices between new and old, innovative and tried-and-true approaches.

Analytic and Management Tools

A variety of analytic and management tools can be useful in setting country objectives, implementing programs, and evaluating outcomes. FPSD would like the services CAs to make greater use of these tools in project design, implementation and evaluation.

Table 7

Subproject Selection Criteria

General

Accordance with AID's project development criteria and FPSD's strategy

- Subproject is appropriate to level of program development of country.
- Subproject documentation includes analysis of rationale and suitability of activity.
- Subproject demonstrates plans for effective collaboration with other CAs, USAID and other donors.
- Plans are adequately developed for ongoing monitoring and evaluation to determine outputs and impact of subproject based on measurable indicators.

Subproject Attributes

Principle 1 – Quality

- Subproject demonstrates concern for quality of services, addresses plans for improvements of quality over time, based on monitoring of measurable indicators of quality care.
- Subproject contributes to family planning environment in a specific way, such as involving an important institution, demonstrating the safety and efficacy of a new delivery mode or improving the quality of services.

Principle 2 – Larger populations, served in cost-effective ways

- Subproject size is large; term is multi-year.
- Number of beneficiaries and CYP to be provided are significant and demonstrate impact on catchment area.
- Subproject life-of-project costs are commensurate with size, duration and expected CYP of the activity.
- Subproject carried out in a cost-effective manner, in conjunction with a stable, local counterpart institution.

Principle 3 – Method mix

- Planned method mix provides the most effective methods appropriate to program users, as defined by client profile.

Principle 4 – Participation of all sectors

- Subproject has considered and involves, as appropriate, leveraging of resources, and the three service delivery sectors (government, NGO, and for-profit).

Principle 5 – Sustainability

- Subproject has been designed to achieve partial or complete financial sustainability prior to termination.
- Cofunding is being contributed, in the amount of XX% in funding or YY% in in-kind.
- Plans for institutional sustainability of the subproject have been laid.

Principle 6 – Comparative advantage, strategic position and managerial efficiency

- Subproject capitalizes on the comparative advantage of the respective CA and its niche in the FPSD portfolio.

Several analytic approaches draw upon the comprehensive national demographic data available from Demographic and Health Surveys (DHS) and other large-scale survey research. These major surveys provide comprehensive national and in some cases regional data on attitudes toward contraception, acceptor profiles, and method mix. Since in a number of countries, more than one national survey has been completed, it is possible to compare current data with that from an earlier point of time and identify changes in attitudes and the practice of family planning.

The TARGET model uses DHS or other national data to estimate the levels of service delivery and method adoption that must be achieved to obtain the desired changes in fertility. Recent improvements in the TARGET model make it possible to estimate the costs associated with achieving these levels. The TARGET model also looks at the impact of other proximate determinants of fertility, such as breastfeeding. DHS data are also used in a new approach to estimate unmet need for family planning. This approach categorizes women according to their contraceptive and reproductive status. Women who are currently pregnant or amenorrheic are considered to have an unmet need if their last birth (or current pregnancy) is either unwanted or mistimed. Similarly, non-pregnant fecund women who want either to space or limit childbearing and who are not using contraception are considered to have an unmet need for family planning.

Somewhat different approaches to planning and evaluation are incorporated in the methodologies for situation analyses, and use of the country typology. Situation analyses provide an overview of national services and contraceptive use based on a standardized review of service delivery outlets on a national or regional scale. The typology uses cumulative experience with family planning program evolution to identify key needs and activities for programs at different stages of development. Country specific information can be used with this model to review options and examine alternative investments.

A.I.D. overseas strategies missions develop Country Development Strategy Statements (CDSS) for each A.I.D.-assisted country. These provide information on the overall and by-sector objectives of A.I.D. assistance that can help CAs plan subproject activities which support USAID's country program objectives.

There are also a number of approaches being tested and used to obtain better information on client satisfaction and program quality. These include use of focus groups, client intercept surveys, client satisfaction surveys and patient flow analysis.

Management information systems provide important information on client characteristics, contraceptive distribution, implementation of specific activities and related costs. Computer-based integrated MIS systems such as those being introduced in Latin America by IPPF/WHR and elsewhere under the Family Planning Management Development project have significant potential not only for timely monitoring and improved management but for significantly improved information on client characteristics, continuation, method choice, and cost-effectiveness.

Monitoring and Evaluation

A.I.D. and the CAs share responsibility for the programming and use of A.I.D. population assistance funds. First, the CA has primary responsibility for establishing and maintaining

evaluation systems that monitor project implementation and determine project performance and impact on the use of family planning. Increasingly, the CAs are expected to have the data necessary to report upon their projects in terms of the CA's overall organizational mission, the project's pre-established objectives and use of A.I.D. resources, and the project's contribution to contraceptive prevalence. Secondly, at the project management level, A.I.D. has parallel responsibilities to monitor project implementation and evaluate the outcome of A.I.D. project assistance. Finally, establishing a comprehensive evaluation program for all A.I.D. population assistance will be a major Office of Population initiative in the nineties. This effort, which builds upon earlier Office of Population successes in improving the data base for population planning and program evaluation, is directed at improving the systems and methodology for evaluating population assistance and improving the understanding of the linkages between family planning programs and contraceptive behavior and fertility.

CA Monitoring and Evaluation

An important part of the more strategic service delivery approach advocated for the nineties is the greater emphasis to be paid to the quality and extent of data collected by CAs as part of their ongoing monitoring and evaluation systems. As part of the process of determining the role and niche of each CA in supporting a country's family planning program, information is needed on who is being assisted with what methods at what costs and how such assistance contributes to eventual program sustainability. At the initial design stage, systematic, ongoing evaluation must be built into project activities to monitor implementation and facilitate examination of program performance. Designs need to include the project objective, verifiable measures for determining progress toward achieving these objectives, and a process for collecting, analyzing and sharing this information. Baseline data are needed for comparison with end-of-project data. Among the data needs are information on program quality, client characteristics and numbers, method mix, service costs and local support. The ability to measure costs and relate these to specific patterns of service utilization has become increasingly important with the concerns about project sustainability. Also needed is information on the mix of local and donor contributions and ways of augmenting population resources through fee collection, leveraging and/or the use of financial mechanisms such as debt swaps, preferential currency exchanges, etc.

FPSD Monitoring and Evaluation

FPSD monitoring systems include the ongoing dialogue between the services CAs and those in FPSD concerned with implementing and monitoring project activities; a series of special monitoring and evaluation activities such as the annual workplan reviews, annual management reviews and the interim or special project evaluations; and FPSD initiatives to develop and maintain better data on service delivery.

Annually, the total program, resource allocations and progress toward achieving agreed objectives are jointly reviewed in the workplan presentations to the Office of Population and the subsequent approval process. FPSD is moving toward a system in which the entirety of a CA's work in a specific country is approved at one time rather than on a subproject-by-subproject basis.

Once a year, joint management reviews provide an opportunity to examine the administrative and financial sides of project implementation and consider project progress, issues and

necessary corrective actions. Among the questions that the management review addresses are the efficiency with which project actions occur; whether project staff is in place and well qualified; whether the project headquarters operates smoothly; whether planning and implementation of TA and training programs take place on schedule; whether the contractor is responsive to FPSD, mission, and host country needs and requests; whether consultants and sub-contractors are well qualified for their tasks, and supplied in a timely manner; whether the overall project workplans and implementation plans are realistic; and whether the contractor provides A.I.D. with information and necessary reports in a timely manner.

Interim or special evaluations provide an opportunity to assess overall project implementation and accomplishments. Usually, such evaluations concentrate on examining indicators that show whether the project has achieved its purpose, and, to a lesser extent, the quality, quantity and timeliness of planned project outputs. Since these evaluations are designed to provide information for specific management decisions, they vary in scope and methodology. An evaluation mid-way through the project period focuses on mid-course corrections for the future, while an evaluation toward the end of the project includes recommendations for design of future activities.

In addition to these activities to monitor program operations, FPSD is involved in two initiatives to develop and maintain better data on service delivery:

1) participation in the Cooperating Agency Task Force on Standardization of Service Statistics, and

2) the development of a portfolio data base, incorporating standard measures developed by the Task Force, for monitoring and reporting on service delivery activities.

Since June 1986, the CA Task Force has been working to develop recommendations on standard project performance indicators. It is recommending common language to describe family planning clients and common factors for the conversion of service statistics to couple years of protection. Based on the common definitions of parameters, FPSD is developing a portfolio data base. The CAs will be adopting the standardized measures in their local programs.

The portfolio data base will be able to track service delivery activities from which service statistics can be aggregated at the level of FPSD. This will make it possible to determine the contribution of FPSD activities to the accomplishments of the Office of Population.

In the summer of 1990, FPSD conducted a survey of the CAs to determine the extent of adoption of the recommended definitions of service parameters, and to determine the volume of services and method mix. The survey queried the CAs about whether their service statistics reflect distribution to outlets or consumers, about conversion factors used in calculating CYP, and about volume and method mix of services provided to new acceptors and in the form of CYP.

The data show where variations still exist in the definitions the CAs use, such as in the conversion factors used to calculate CYP. With respect to volume of services, the data also reflect considerable differences, beyond those related to the different funding levels of CA programs. These differences may stem from program goals, innovativeness or risk of program activities, the newness of activities or difficulty of the program site. The CAs also differ in method mix, with some CA programs emphasizing supply methods and others putting more reliance on more effective, clinical methods.

The data are useful to FPSD in two ways. First, they are the beginnings of a data base on services supported by FPSD as a whole. Second, they are a management tool by which FPSD and the CAs can look at method mix and changes in method mix over time. Further service volume can be related to CA goals, objectives, and funding levels. This enables FPSD and the CAs to review their programs with a view to whether they are progressing as planned.

Over time, it may be useful for FPSD and the CAs to work together to build up the data base on service delivery. This would include continuing to collect service data on an annual basis, and working with the CAs to assure that common definitions of parameters are in place. New acceptor and CYP information are the first two building blocks in the data base. As measures of service output and quality are improved, monitoring information may improve commensurately. Further, to meet data needs of the nineties, FPSD and the CAs may want to add additional measures to the service data collected. For example, to look at improvements in method mix over time and appropriateness of method to the profile of the acceptor, it may be useful to add age and parity information to the basic service data.

Office of Population Evaluation Initiative

A.I.D. is giving priority to the development of improved systems and methodology for evaluating the impact of population assistance on fertility. A new evaluation unit is being established within the Office of the Population's Policy Division. This unit will focus on ways to measure the overall program impact of A.I.D. population assistance and will design a comprehensive evaluation plan for all A.I.D. population assistance, develop common evaluation criteria and standards, and support data analysis, dissemination and use and methodological studies to improve the measures and systems available to evaluate program impact and effectiveness. As part of this effort, FPSD will be marshalling impact evaluation data on the activities it sponsors obtained by comparing baseline and end-of-project data, related to such aspects as prevalence, client characteristics, method mix, and program quality.

Issues for the Nineties

Considerable progress was made in the eighties in developing alternative multisector approaches to service delivery; understanding the importance of quality, market segmentation and cost in family planning service delivery; and appreciating the need to be more strategic in planning, coordinating and managing family planning resources. The systems and methodologies to support these activities and make important management decisions are still rudimentary and in some cases clearly inadequate.

Three areas that require further attention are 1) coordination of donor and CA inputs; 2) better measures of quality impact, and sustainability; and 3) joint planning and analysis.

Donor and CA Coordination

Given improvements in the family planning environment, knowledge of effective approaches and local institutional capability, it is no longer cost effective to have multiple donors or CAs working with the same institutions in the same country. Such duplication of effort is costly both

for the recipient and the assistance agency. FPSD has been discussing with the CAs ways to improve coordination of efforts, promote the exchange of information and eliminate overlapping activities.

Such coordination becomes increasingly important when the concept of comparative advantage of the CAs is considered. Each CA has different strengths and specialties. The CAs are not expected to have equal expertise in all areas -- management, marketing, MIS, training, materials development, technical aspects of client care -- and FPSD cannot endow the CAs each with the funding to attain this equal expertise.

Patterns of collaboration and sharing of expertise need to be developed along with ways of rewarding institutions which participate in such exchanges. Among the approaches that are currently being used are systematic collection and dissemination of information on all A.I.D.-financed population assistance by country; donor country meetings; joint planning by A.I.D., the World Bank, UNFPA, and other donors for country population assistance; annual country meetings which include all concerned CAs, mission and local counterparts; shared overseas facilities for CA regional or country offices; formal Washington reviews focusing on specific countries or sets of countries; inclusion of plans for coordination and collaboration in CA strategies and workplans; informal meetings; and conference calls.

Better Measures

Considerable progress has been made in identifying critical program issues and parameters. In the nineties, equal attention will have to be paid to defining and developing manageable measures of important program dimensions, such as quality, impact, continuation rates, sustainability, return on investment, and cost effectiveness so that agreement may be reached on standard measures.

A good example of an area in which progress has been made but in which further work is critical is in measuring quality. Pioneering work by researchers such as Anrudh Jain and Judith Bruce of the Population Council has contributed to the formal recognition of the importance of quality in service delivery. Over the past year a CA Task Force has been working to expand this work and develop guidance for program managers. Agreement has been reached on some of the critical components of quality service delivery. Accurate, affordable ways of measuring these components of quality such as continuation rates, and client/provider knowledge and interaction still remain to be developed. Cost and cost- effectiveness provide further examples of important areas where despite considerable work, reliable practical approaches are lacking.

Equally, important major concepts such as program sustainability or the impact of assistance, which receive broad theoretical support lack clear definition and tools for measurement and monitoring. The tools for measuring impact are limited at present. Impact data, however, are vital to program management. Easy-to-use, reliable indicators of continuation are needed, in addition to CYP and new acceptor counts. Measures of continuation will help to reflect programs that have strong IEC components or that are active in helping acceptors to use methods which meet their needs, as these needs change over time.

Joint Planning and Analysis

This paper has attempted to show how strategic thinking and planning, based on an understanding of past successes and experience and an appreciation of future trends in population development, can better equip FPSD and the A.I.D. service delivery community to face the challenges of the nineteen nineties. This is an evolutionary process, incorporating past dialogue with CAs into current thinking and initiating further dialogue about joint endeavors for the future.

FPSD has reviewed past accomplishments and experience with family planning and examined future demand to target its own planning to meet future needs. From the lessons learned, FPSD has identified a number of principles on which successful interventions in the nineties should be founded. These principles include the importance of client-responsive, quality care; of provision of an effective method mix; of involvement of the public, PVO and for-profit sectors in collaboration to meet projected demand; and the importance of sustainable services.

Applying the principles requires a strategic and analytic approach to family planning service delivery. The strategic approach highlights the need to coordinate, allocate, implement and manage activities. S&T/POP/FPSD has taken a number of important steps to institutionalize such an approach. These include the establishment of goals and objectives, targets for regional portfolio mix, country priorities and annual reviews of CA strategies and workplans. Greater stress has been placed on data sources such as the DHS and other large-scale surveys for planning, management information systems for monitoring, and analytic tools such as the TARGET model to relate contraceptive methods to prevalence and fertility. Ways to enhance coordination with and between CAs, USAID, and other donors are being addressed. The strategic approach, along with the dialogue that informs and shapes it, will further strengthen the collaborative work of FPSD and the CAs and help achieve the goal of increasing access to voluntary family planning services throughout the developing world.

Appendices

Appendix A

Socioeconomic Characteristics of Country Categories
Average Values

Appendix A

Socioeconomic Characteristics of Country Categories
Average Values

	Emergent	Launch	Growth	Consolidation	Mature
FAMILY PLANNING					
Modern method prevalence	2	11	26	40	55
Total prevalence	4	17	37	54	59
DEMOGRAPHY					
Total fertility rate	6.4	6.4	5.3	3.7	3.4
Population growth rate	2.8	2.8	2.8	2.2	1.8
ECONOMY					
GNP/capita	295	338	437	738	1,680
GNP/cap growth rate	0.0	0.0	1.9	2.3	2.4
Percent GNP in agriculture	37	24	19	17	11
URBANIZATION					
Percent urban	26	25	38	52	60
Percent of population in cities over 500,000	25	10	36	48	48
HEALTH					
Life expectancy	49	51	60	67	67
Maternal mortality rate	645	460	275	218	108
Infant mortality rate	116	118	76	50	45
Daily calorie supply	2,136	2,222	2,440	2,606	2,579
Percent of births attended by health staff	41	N/A	45	66	67
EDUCATION					
Primary enrollment rate	61	83	95	109	106
Female primary enrollment rate	44	73	90	106	106
Secondary enrollment rate	16	20	38	54	49
Female secondary enrollment rate	10	15	34	53	42

Source: World Development Report 1989, World Bank.

Appendix B

Program Elements and the Typology

Program Elements and the Typology

Programming Principles	Emergent	Launch	Growth	Consolidation	Mature
	0-7%	8-15%	16-34%	35-49%	≥50%
Data Needs for Monitoring and Evaluation Quality	Quality control (QC) monitoring ad hoc. Needs to be institutionalized.	Service standards protocols. Development of ways to monitor client satisfaction.	Increased QC monitoring with starting of VSC programs. Monitoring mostly by donors/CAs. Systems for QC monitoring in private sector develop.	Greatly increased QC monitoring as VSC takes off. Shared monitoring by programs + CAs. Marginal quality programs drop out – not sustained.	QC institutionalized. Programs self-monitored for most part.
Quantity	New Acceptor data	Add CYP data	Add continuing user data	Contraceptive prevalence	Total fertility rates
Cost	Track flow of funds.	Tests of strategies to improve cost-effectiveness. Cost per user calculated.	Cost per CYP calculated and used by decision makers.		Marginal costs for provision of FP important to determine where donor/government grants go.
Program Development Program Management	Management training for expansion and quality of care.	Introduction and installation of basic administrative procedures. Development of supervisory system.	Management training for management of more complex programs. Refinement of administrative procedures.	Ongoing managerial training. Installation of MIS and other more sophisticated administrative procedures. Monitoring and Evaluation.	
General Training	Training for promotion to additional groups for voluntarism and quality of care.	Training of CBD workers. Training of trainers.	Growth of multi-method promotion. Training for mobile team distribution. Clinical training for highly effective methods.		

Program Elements and the Typology

Programming Principles	Emergent	Launch	Growth	Consolidation	Mature
	0-7%	8-15%	16-34%	35-49%	≥50%
Clinical Training	In-service training for clinical workers for pills.	Training clinical workers (including paramedicals) for IUDs. Norplant® training. Training for pill sales (e.g., pharmacies). Training for VSC.	Norplant® training expands. Training of rural clinical workers. In-service training for local MDs, including GPs in female VSC.	In-service and preservice training of MDs in male VSC.	Training of private sector MDs VSC/ Norplant® in cost-sustainable manner.
Contraceptive Logistics Management	Small, rudimentary systems to supply fragmented delivery system.	System needs to expand. Distribution, inventory, warehousing systems, etc. need to be upgraded.	Logistics MIS needed. Distribution, warehousing and inventory continue to be developed.		Program can develop orders and procure commodities itself. MIS in place. Warehousing and testing systems OK.
Information Needs	General awareness. Constituency building.	To counter rumor; promote small family ideal; promote services and method specific materials for general use of acceptors.	Mass media to recruit many acceptors, including illiterate acceptors, and for promoting VSC.	Mass media responsive to a more heterogeneous clientele.	Targeted materials for specific groups/ methods, e.g. vasectomy.
Policy	Policy goal to support small family, to support family planning for health reasons, creating awareness of population situation.	Obtain government support for family planning. Test strategies to remove policy/ trade barriers.	Removal of restrictive barriers, e.g. trade, laws, etc. for full implementation of public and private sector program.	Policy and attitudinal barriers to various kinds of contraceptives addressed.	

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Appendix C

FPSD FY 1991 Priority Countries

Appendix C

FPSD FY 1991 Priority Countries

HIGH PRIORITY

FPSD Support to countries without bilateral population programs.

Country	Population (Millions)
Brazil	150.4
Colombia	31.8
Cote d'Ivoire	12.6
Guinea	7.3
India	853.4
Malawi	9.2
Mexico	88.6
Togo	3.7
Turkey	56.7
9 Countries Total Population	1,213.7

Buy-ins to FPSD projects for countries with bilateral population support.

Country	Population (Millions)
Bangladesh	114.8
Cameroon	11.1
Egypt	54.7
Haiti	6.5
Madagascar	12
Nepal	19.1
Nigeria	118.8
Pakistan	114.6
Peru	21.9
Philippines	66.1
Rwanda	7.3
Tanzania	26
Uganda	18
Zimbabwe	9.7
14 Countries Total Population	600.6

MEDIUM PRIORITY

FPSD Support to countries without bilateral population programs.

Country	Population (Millions)
Mozambique	15.7
Papua New Guinea	4
South Pacific	0.2
Thailand	55.7
Yemen	8.1
Zambia	9.8
Mexico	8.1
7 Countries Total Population	101.6

Buy-ins to FPSD projects for countries with bilateral population support.

Country	Population (Millions)
Bolivia	7.3
Botswana	1.2
Burkina Faso	9.1
Burundi	5.6
Dominican Republic	7.2
Ecuador	10.7
Ghana	15
Guatemala	9.2
Indonesia	189.4
Jamaica	2.4
Jordan	4.1
Kenya	24.6
Mali	8.1
Morocco	25.6
Niger	7.9
Senegal	7.4
Sri Lanka	17.2
Zaire	36.6
17 Countries Total Population	388.6

Appendix D

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Appendix D

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